NURSING HOME GUIDELINES
AKA "THE PURPLE BOOK"

- Prevention & Protection
- Incident Identification
- Investigation
- Reporting

FIFTH EDITION
PARTNERS IN PROTECTION

FEBRUARY 2012

SELECTED RESOURCES

- For access to your city, county police, sheriff or other law enforcement agencies, use your local phone directory or visit
  http://www.the911site.com/911pd/washington.shtml

  Emergency situations– DIAL 9-1-1 or your county's emergency services number
  Non-emergency situations – use local numbers for Police/Sheriff/State Patrol

- For access to contact information and the phone number of your county's Coroner or Medical Examiner, visit
  http://www.dahp.wa.gov/sites/default/files/WA%20State%20Medical%20Examiners-Coroners.pdf

- For access to a complete archive of the Department's letters and other basic information and links to other resources for NH professionals, residents and families, advocates, interested parties, and the general public, visit:
  http://www.adsa.dshs.wa.gov/professional/nh.htm

- For access to the most current criminal history disclosure information from the Department of Social and Health Services Secretary's List of Crimes and Negative Actions that may be amended or updated at any time, visit:
  http://www.dshs.wa.gov/bccu/bccucrimeslist.shtml and select Nursing Homes (bullet under Item #1 – RCS). See also WAC 388-97-1820, Disqualification from Nursing Home Employment.

  For access to the Department's brochure, *Partners in Protection: A Guide for Reporting Vulnerable Adult Abuse* (DSHS 22-810X), written and available in English and seven other languages to help protect residents from abandonment, abuse, neglect and financial exploitation, visit:
  http://www.adsa.dshs.wa.gov/Library/publications/brochurestext.htm#abuse_mandated

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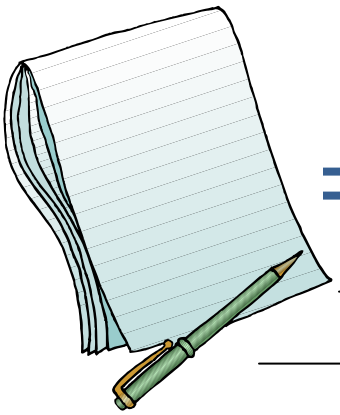

Notes

INTRODUCTION

This document contains guidelines for the protection of nursing home residents along with guidelines for preventing, investigating, determining, and reporting incidents of resident abuse, neglect and mistreatment, injuries of unknown source, exploitation, misappropriation of resident property in nursing homes, including reporting reasonable suspicion of a crime in a Long-Term Care (LTC) facility.

The word "resident" or "client" as used throughout is equivalent to the term "vulnerable adult" as defined in state law.

These guidelines also contain portions of and references to:

- Chapter 74.34 Revised Code of Washington (RCW), Abuse of Vulnerable Adults;
- Chapter 388-97 Washington Administrative Code (WAC) – Nursing Homes.
- Code of Federal Regulations (CFR) Part 483 – Requirements for State and Long-Term Care Facilities;
- CFR Part 488 – Survey, Certification, and Enforcement Procedures; and
- The Elder Justice Act of 2009, Section 1150B of the Social Security Act – Reporting possible crimes to law enforcement.

A variety of actions fall within the definition of abuse. An action can be abusive even if there is no intent to cause harm. Assault is a crime and requires intent to cause harm. As used in these guidelines, an assault is always abuse, but some abusive actions may not amount to an assault.

These guidelines are intended to assist facilities in developing and implementing principles and procedures to help prevent resident abuse of all types, neglect, criminal mistreatment, financial exploitation, and misappropriation of resident property by any person. The principles and procedures developed should promote resident protection and prevent abuse, neglect and other mistreatment by providing facility staff with the necessary direction and information.

These guidelines also contain general information to help the facility in determining if abuse, neglect, negligent treatment, mistreatment, exploitation, a reportable injury of unknown source, or misappropriation of resident property is likely to have occurred. They also contain information about reporting requirements that apply to facilities and reporting requirements that apply to individuals, including facility owners, operators and employees.

Effective March 23, 2011, there are **federal** requirements that require certain individuals in federally funded long-term care facilities to timely report any reasonable suspicion of a crime committed against a resident of that facility. There are specific facility-related responsibilities under Section 1150B of the Social Security Act including the following:

A Medicare or Medicaid-participating LTC facility **must:**

- Notify covered individuals annually of their reporting requirements;
- Prevent retaliation if an employee makes a report;
- Post information about employee rights, including the right to file a complaint if a long term care facility retaliates against anyone who files a report.

Principles and procedures must also be established and implemented for the employment of new staff members, for the use of volunteers, and students. It is the responsibility of the nursing home to:

- Check the OBRA Nurse Aide Registry to ensure OBRA certification, prior to the employment of a nursing assistant;
- Conduct criminal history background checks on all staff, volunteers, and students who have unsupervised access to vulnerable adults, within 72 hours of conditional employment;
- Ensure all staff, including agency-contracted personnel, are free of any disqualifying criminal history.

Contact your local Residential Care Services (RCS) District Administrator or RCS Field Manager if you have questions about this document or its guidelines.

NOTE: None of these guidelines are intended to replace federal and state law regarding abuse and neglect.

PURPOSE

The incident identification, investigation and reporting guidelines in this document are designed to assist nursing homes in complying with the requirements of the state Vulnerable Adult Act, Chapter 74.34 RCW, the Medicare and Medicaid nursing facility requirements including 42 CFR 483.13, and, the Elder Justice Act of 2009, Section 1150B of the Social Security Act – Reporting possible crimes to law enforcement.

Some of the federal requirements became effective in 2011 and other requirements already existed under Washington state law. **NOTE:** If there is a difference between federal and state reporting requirements, you must follow whichever law is the ***most stringent***.

The guidelines are intended for use primarily by:

- Nursing homes and nursing home employees;
- Department of Social and Health Services (DSHS) employees; and
- Health professionals.

Other individuals or agencies who may want to utilize these guidelines include:

- Residents and families;
- Law enforcement agencies;
- Community agencies and concerned citizens; and
- Long-Term Care Ombudsman staff and volunteers.

The guidelines provide:

- General information to be applied in determining whether abuse, neglect, abandonment, exploitation, or misappropriation of resident property has occurred;
- General information to be applied in determining what and when to report any reasonable suspicion of a crime against a resident in a long term care facility, including nursing facilities and skilled nursing facilities;
- The nursing home's responsibility in reporting, investigating, and taking appropriate corrective and preventative measures; and
- The rights and responsibilities of persons reporting to DSHS Complaint Resolution Unit.

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CHAPTER I
FACILITY REPORTING REQUIREMENTS

24 hour Hotline: 1-800-562-6078

Effective March 23, 2011, the federal Elder Justice Act of 2009 requires that a participating Long-Term Care (LTC) facility (Facility), including nursing facilities that participate in the Medicare or Medicaid programs, **must:**

- **Notify Covered Individuals**: The Facility must notify covered individuals annually of their duty to report suspected crimes, as required in Section 1150(b) of the Social Security Act;

- **Post Conspicuous Notice:** The Facility must post a conspicuous sign in an appropriate location notifying covered individuals of their rights under this law. This sign must include a statement than an employee may file a complaint against a Facility that retaliates against an employee who complies with this law and must also provide information about the way to file a complaint; and

- **Refrain from Retaliation:** The Facility is prohibited from retaliating against anyone who files a complaint under this law. Retaliation includes discharge, demotion, suspension, harassment, denial of promotion, or the filing of a professional licensing complaint. Penalties could include a civil penalty of up to $200,000 and exclusion from federal contraction.

The Facility is required, by federal and state law, to protect residents, and to investigate and report certain events. The guidelines that follow do not exempt the facility from using good judgment in determining the best course of action to be taken in order to protect vulnerable adults.

The prioritization that follows is just a reminder of what the facility must do and the order in which it should be done. (Reporting and investigation may be undertaken simultaneously.) **Remember to protect, and investigate and report.**

1ST PRIORITY: Protect the victim(s)/resident(s) from further harm.

2ND PRIORITY: Perform a thorough investigation, and report to the Department and law enforcement as required.

NOTE: The facility must designate a person or persons to do the facility reporting required by federal and state law. Facility staff must know who that person is.

Facilities are required to Report to:

1. **The Department's 24 hour Hotline:**
   - The Department's hotline number is **1-800-562-6078**. The number is available 24 hours a day, seven days a week, and the time and date of messages are recorded.
   - If the information the facility provided to the CRU in its initial report is substantially the same as the information the facility learned during its investigation, then the investigation results should be documented and placed in a facility file that will be available to surveyors or complaint investigators when requested.
   - If, during its investigation, the facility learns additional information that is pertinent to the incident or that substantially changes the information contained in the initial CRU report, the facility must provide the results of the investigation (or the status of an ongoing investigation) to the CRU hotline (1-800-562-6078) within five (5) working days.

2. **Law Enforcement:**
   - In an **emergency**, call **9-1-1** or the emergency services number.
   - For **non-emergency** situations, use the local number specified by your local law enforcement authorities.
   - You can locate police, sheriff and other law enforcement agencies for the state, cities and counties in Washington at: http://www.the911site.com/911pd/washington.shtml or use your local phone directory.

3. **Coroner/Medical Examiner:**
   - Even if a death appears to be due to natural causes, the facility is required to call the county's Coroner or Medical Examiner to report any resident death in which abuse or neglect could be a possibility; or, as required for other reportable circumstances as identified under RCW 68.50.010.
   - Refer to WAC 388-97-0640, Prevention of Abuse, for rules related to reporting requirements under chapter 74.34 RCW and 42 CFR 483.13.
   - You can locate your county's Coroner or Medical Examiner contact information at: http://www.dahp.wa.gov/sites/default/files/WA%20State%20Medical%20Examiners-Coroners.pdf

4. **State Department of Health:**
   - In certain circumstances, the nursing home is required to report an employee who is a license or certificate holder, usually a nurse or a certified or registered nursing assistant, to the appropriate disciplining authority at the State Department of Health (DOH), Health Professions Quality Assurance Division. For specifics, refer to WAC 388-97-0640(4)(5), Prevention of Abuse.
   - These reports must be submitted to the disciplining authority as soon as possible. Contact DOH Customer Service at 360-236-4700 or on the Internet at hsqa.csc@doh.wa.gov.

Methods of Reporting:

- By telephone; and
- By the "Reporting Log."

The facility must maintain a state "Reporting Log" (see Appendix E). The log must be retained in the facility and readily accessible at all times to state licensing and certification staff, and others according to their authority. Minimally, the log must contain the information indicated on the model form seen at Appendix E, using the prescribed format and codes. Other information may be added if desired by the facility. Log entries must be retained and preserved by the facility for a period of no less than three years.

When to Report:

- **Immediate** telephone reporting is required for allegations of abuse, neglect, exploitation and misappropriation.
- Substantial injuries of unknown source must be reported **within 24 hours**.
- On the reporting log within **5 days** of discovery.

Where to Report by Telephone:

- Call the Department's hotline number **1-800-562-6078**, unless directed otherwise. The number is available 24 hours a day, seven days a week, and the time and date of the messages are recorded.
- Call local law enforcement or **9-1-1.**

What to Report to the Department by Telephone and via the Reporting Log:

- All alleged violations involving abandonment, abuse, neglect, or mistreatment, including injuries of unknown source and misappropriation of resident property;
- Any reasonable suspicion of a crime, including physical or sexual assault, has been committed against a resident;
- Any act, when there is reasonable cause to believe the act caused a fear of imminent harm; and
- Substantial injuries of unknown source (***not*** related to suspected abuse or neglect), because under some circumstances the failure to take preventive measures may constitute abuse or neglect.

What to Report to Law Enforcement:

- When there is a reason to suspect that sexual assault or physical assault against a resident has occurred (***except*** under circumstances described below).
- When there is reasonable cause to believe that an act has caused fear of imminent harm.
- Limited Exception: An incident of physical assault between residents always has to be reported to the Department, but does not have to be reported to Law Enforcement, ***unless***

(a) it caused more than minor bodily injury ***and*** *r*equired more than basic first aid, ***or if*** the injury appears on the back, face, head, neck, chest, breasts, groin, inner thigh, buttock, genital, or anal area; there is a fracture; there is a pattern of physical assault between the same residents or involving the same residents; or there is an attempt to choke a resident, or

(b) the injured resident or his or her legal representative or family member asks that a report be made.

What to Report to County Coroner or Medical Examiner:

- A facility must report the death of a resident living in a nursing home in which there may have been abuse or neglect (criminal mistreatment), or other reportable circumstances, even if the death otherwise appears to be due to natural causes. Once reported, and if jurisdiction is taken, your county's Coroner or Medical Examiner is responsible for investigating the cause and manner of death to decide the most appropriate death certification for that resident.

What to Report to the State Department of Health's Disciplining Authority for License Holders:

- The nursing home must report to the Department of Health, any employee/staff person who is a health care professional, including a licensed nurse, or a registered or certified nursing assistant, against whom there are allegations involving abandonment, abuse, neglect, financial exploitation, or, misappropriation of resident property.
- The nursing home must report any information it has about an action taken by a court of law against an employee to the Department's hotline *and* to the appropriate Department of Health licensing authority, if that action would disqualify the individual from employment as described in RCW 43.43.842.

What to Report via the "Reporting Log" only (Within 5 days of Discovery):

- Substantial injuries of unknown source determined through the process of *investigation* to be reasonably related to the resident's condition, diagnoses, known and predictable interactions with surroundings, or a known sequence of prior events.

Remember that the facility has to report substantial injuries of unknown source within 24 hours. *However*, if during your investigation, before the 24-hour period is up, you determine that the injury is reasonably related to the resident's condition as defined in Appendix J, you may report by log entry.

- Superficial injuries of unknown source (***not*** incidents of suspected abuse or neglect). Superficial injuries are injuries determined through the process of *assessment* to be reasonably related to the resident's condition, diagnoses, known and predictable interactions with surroundings, or known sequence of prior events.

CHAPTER II
THE INVESTIGATION PROCESS

Quality not quantity is the most important feature of any investigation

All alleged incidents of abandonment, abuse, neglect, or mistreatment, including injuries of unknown source and misappropriation of resident property must be thoroughly investigated. The investigation is done to determine, as far as possible:

- What occurred; and
- To make necessary changes to the provision of care and services to prevent reoccurrence.

A thorough investigation is a systematic collection and review of evidence/information that describes and explains an event or a series of events. It seeks to determine if abandonment, abuse, neglect or misappropriation of resident property occurred, and how to prevent further occurrences.

Critical components of any investigation include:

- The objectivity of the investigator.
- The timeliness of the initiation of the investigation; and
- The thoroughness of the investigation.

The facility must develop and implement written principles and procedures to help organize the investigative process so that it can start as soon as possible and continues in an organized manner. The principles and procedures must include the responsibilities of staff who conduct investigations. The facility must train staff on the applicable federal and state regulations, the facility principles and procedures regarding abuse and neglect including investigations, and on the skills required to perform a thorough investigation.

Staff must protect residents from harm, *immediately* report incidents as required by federal and state law, and begin investigations as soon as possible. The nursing home and their staff must also *immediately*:

- Protect resident(s) from reoccurrence; and
- Take any action necessary to treat the ill effect(s) experienced by the resident(s) as a result of the alleged incident(s).

Objectivity of the Investigator

The investigator of any incident must be objective and neutral during the course of the investigation. Investigators must:

- **Begin** with a “ruling out” of the fact that abandonment, abuse, neglect, mistreatment, exploitation, or misappropriation of resident property could have occurred; and
- **Not Begin** with a presumption of guilt or innocence of an individual(s).

The investigator must look at the incident fairly and without bias, and collect as much accurate data as needed to be able to reach a reasonable conclusion.

The Timeliness of the Investigation

The facility must begin the investigation in order to collect accurate data related to the incident. Any delay in starting the investigation can cause valuable information to be either lost or altered.

Thoroughness of the Investigation

Federal law requires the nursing home to do a thorough investigation of the incident. In order for the facility to provide evidence of the thoroughness of the investigation the information must be recorded.

A thorough investigation ***may*** require two phases of fact gathering:

- The first phase must be completed within 24 hours of knowledge of the incident, and begun, if possible, as soon as the incident is identified and the alleged victim protected.
- If the first phase is not successful in determining a reasonable cause, an extended or second phase must follow.

The investigation should end with the identification of who was involved in the incident, and what, when, where, why, and how the incident happened, including the probable or reasonable cause. It should also allow the nursing home to determine if the allegations were true or not. The amount of time and resources necessary for an investigation will vary depending upon the nature of the allegation or incident.

Each phase of a thorough investigation includes two steps:

- Data collection; and
- Data analysis.

Data Collection

The following questions should be reviewed to determine which apply to the particular incident. These examples are not all inclusive and only those that relate to a particular incident should be selected. You may need to add other questions that relate to the situation.

WHO:

- Who witnessed the incident?
- Who is (are) the alleged suspect(s) or who may have contributed to the occurrence of the incident?
- Who is (are) the alleged victim(s)?
- Who spoke to the alleged victim(s) regarding the incident?
- Who else may have information related to the incident?

WHAT:

- What is the incident?
- What is the chronological order of action leading up to the alleged incident?
- What are the injuries?
- What information does the alleged victim have regarding the incident?
- What did the discovering person or witness see, hear or smell?

- What did these people do in relation to first discovering the incident?
- What information do other staff members have of the incident or factor(s) leading up to the incident?
- What was the functional, mental and cognitive status of the alleged victim before and after the incident?
- What is known about the alleged suspect(s) or person(s) who may have contributed to the occurrence of the incident?
- What did the physical environment, where the incident occurred, look like? Were there any spills or tripping hazards? Were any medical devices being used?
- What were the victim and alleged perpetrator doing at the time of the incident?
- What was happening to the alleged victim just prior to the incident?
- What precipitating factors were identified?

WHEN:

- When was the incident discovered? By whom?
- When did the incident occur? (be as specific as possible related to time of day or night)

WHERE:

- Where did the incident occur? (exact location if known)

Data Analysis: Should Answer the HOW / WHY of the Incident

Summarize and analyze the facts gathered to either establish reasonable cause for the incident, or establish the need for further investigation.

- How did the incident occur?
- How was this incident avoidable? (Were there factors that made this incident unavoidable?)
- Why did the injury or incident occur?

An analysis of the data gathered should establish a reasonable cause. If not, more information may be needed or there may be a need for further investigation.

PHASE ONE: INITIAL INVESTIGATION (Within the first 24 hours)

NOTE: When abuse or neglect is not suspected and the injury is of unknown cause, some injuries may be determined, during the course of the investigation, to be reasonably related to the medical and/or functional condition of the resident. In such cases it would not be necessary to complete other investigative elements.

If during any phase of the investigation the investigator has a reason to suspect abuse or neglect, it must be *immediately* reported to the Department.

For this investigative phase only the elements on the following list, that are appropriate to the circumstances surrounding the incident, should be considered. This list is ***not*** all-inclusive

- Interview the alleged resident victim.
- Interview witnesses, including but not necessarily limited to:
  - Assigned caregiver;
  - Caregivers in immediate area;
  - Caregivers from the shifts prior to the incident discovery;

    - Remote or potential witnesses, such as visitors, family, roommates; and
    - Alleged perpetrator.
- Review the resident victim's medical condition.
- Review the resident victim's normal interaction with the environment.
- Observe environment where incident was likely to have occurred.
- Assess current cognitive status of victim.
- Physical exam.
- Diagnostic work, if needed.
- Comprehensive record review of the resident victim and others as appropriate, this may include but is not necessarily limited to the following elements depending on the nature of the incident:
    - Progress notes;
    - Flow sheets and care plans;
    - Physician orders;
    - Laboratory results;
    - Assessments: MDS, triggered CAAs, and other assessments;
    - Social and psychological history;
    - Diagnosis/problem list; and
    - Injury trends, similar incidents and injuries, related quality assurance system documents (for facility investigator).

See also: "Preservation of Evidence" on the following page.

The first phase of the investigation should:

- Answer "who, what, when, where, why, and how";
- Enable the investigator to record the "who, what, when, where, why, and how" information; and
- Establish a reasonable cause or known source of the incident or injury within 24 hours of the incident or injury.

If the investigator is unable to establish a reasonable cause or known source, further investigation is required.

PHASE TWO: EXTENDED INVESTIGATION (After the first 24 hours)

Further investigation is required if the first phase of the facility investigation did not establish reasonable cause or source of allegation or injury within 24 hours. The following elements may need to be included and considered:

- Interviews of expanded sample of witnesses, historians;
- Expand the time frame surrounding the incident for collecting data;
- Follow up on new information;
- Obtain related professional expertise; and
- If the suspected perpetrator is staff, interview the other residents the staff person was assigned to.
- See also: "Preservation of Evidence" on the following page.

Additional information obtained in Phase Two of the investigation should allow the investigator to answer "who, what, when where, why and how" and lead to the

establishment of a reasonable cause or a known source of the allegation or injury, if possible. If the cause or reasonable cause cannot be established in either investigative phase, the cause should be reported as unknown.

Extended investigation findings must be entered into the Reporting Log and be available within five days of the discovery of the incident or injury. The entry may require updating as the investigation moves forward. See Chapter I for facility reporting requirements. Refer also to Appendix A and Appendix B (Diagrams for Abuse and Neglect).

CORRECTIVE ACTION REQUIRED FOLLOWING THE INVESTIGATION

After the investigative phase(s) is completed, the nursing home is required to take action based upon the findings in order to correct the known and reasonable causes as well as to prevent further reoccurrence of the alleged incident(s).

EVIDENCE OF INVESTIGATION – FIRST PHASE AND EXTENDED

The resident's record must include enough information about the incident to enable staff to identify, plan for and meet the resident's needs. Documentation of incidents resulting in injury must provide enough information to identify the nature of the injury, and the facts that relate the injury to the condition of the resident. This will allow staff to appropriately plan for and meet the resident's needs.

Evidence of investigation must be readily available to state licensing and certification staff and others according to their authority. This documentation may be in the format and location selected by the facility and must contain information and facts that address "who, what, when, where, how and why" of the incident.

All documentation of evidence of investigation of incidents must be retained by the nursing home for the period of three years. For a more detailed description of a facility's obligations to maintain resident records, refer to RCW 18.51.300.

Preservation of Evidence

The first step of proper evidence collection is thorough documentation recorded as soon as possible. Identification, protection, collection, preservation and security of relevant evidence identified during the course of the nursing home's investigation is essential and especially important when dealing with serious events or potential criminal incidents.

Documentation of the date and time of collection must be included for all evidence gathered. If possible, write the date, time and name of staff person collecting the evidence on the article of evidence when appropriate, such as on the back of a picture or on the individually packaged and sealed bag of evidence.

Evidence Collected During the Facility's Investigative Activities May Include the Following:

1. **Witness statements**: Written, signed, and dated by the individual providing the statement. This evidence should be collected on a one-to-one basis, and as soon as possible after an incident/event, in order to avoid the witness becoming confused by hearing other accounts of what occurred. These statements should describe in as much

detail as possible what the witness observed. The facility staff person receiving such statements should also sign and date the document. Blank areas on the paper of such statements should be crossed out and initialed.

2. **Other document evidence**: Attached to the facility's investigative report. Examples of document evidence include but are not limited to: laboratory test results, monitoring notes, comprehensive care plans, staff attendance records, names of emergency services responders to the scene and other such written evidence.

3. **Physical evidence**: If law enforcement will be arriving on the scene, physical evidence should be left in place and the scene secured until law enforcement arrives and can process it. If law enforcement will not be arriving quickly or the scene cannot be preserved, physical evidence should be photographed, then secured and preserved from contamination until law enforcement can take custody of it. Examples of physical evidence include but are not limited to: weapons, the resident's body, care supplies and equipment, clothing, linen, medication or other items at the scene.

4. **Demonstrative evidence**: Photos of bruising, drawn diagrams of the location or room of the incident/event, audio or video tapes should also be attached to or kept with the facility's documentation of its investigative actions, findings, along with appropriate measures taken to prevent similar future situations if the alleged or suspected incident is substantiated.

Each nursing home must establish their own internal policies and procedures to guide their investigators in how to do proper evidence collection, documentation and preservation. For example, a facility's investigation guidance could include, but would not need to be limited to:

- How to systematically identify possible sources of evidence to collect for the investigation of allegations/events of suspected incidents of abandonment, abuse, exploitation, financial exploitation, neglect, or mistreatment, including injuries of unknown source;
- How to secure the scene of a resident's location of serious injury or death for the arrival of law enforcement;
- How to keep an accurate inventory of an investigation's types of collected evidence;
- How to obtain consent from a resident or resident representative to allow for collection of photographic evidence;
- Where in the facility to find supplies for the collection of physical evidence, such as, plastic or paper bags, zip lock bags, marking pens, and, labels/seals;
- How to protect the integrity of physical evidence – such as, packaging each item individually; not permitting pieces of evidence collected from different individuals to come in contact with or placed on the same surface as each other preventing the accidental transfer of evidence; and proper handling of wet/damp pieces of evidence;
- How to maintain a documented chain of custody for physical evidence; and
- How to properly transfer evidence from one person or location to another, such as from the facility to law enforcement.

CHAPTER III
INDIVIDUAL MANDATED REPORTING REQUIREMENTS

24 hour Hotline: 1-800-562-6078

Under state law, the individual mandated reporter requirements are described in RCW 74.34.035-053. A mandated reporter includes but is not limited to an employee of the Department; a law enforcement officer, an employee of a facility; a social worker or health care provider and an operator of a facility.

For the purposes of reporting abuse, abandonment, neglect, financial exploitation, sexual assault and physical assault, a nursing home employee (or other mandated reporter) is required to make a report if he or she:

- Observes the incident or hears the victim state it happened; or
- Hears about an incident from a permissive reporter who has direct knowledge of the incident.

NOTE: An employee who hears about the incident from a mandated reporter and who believes that the report has been made does ***not*** have to make a report.

This individual mandated reporting does ***not*** take the place of the facility reporting required in Chapter I.

Under federal law, covered individuals must report a reasonable suspicion of a crime against a resident to the appropriate law enforcement agency. A covered individual means anyone who is an owner, operator, employee, manager, agent, or contractor of a Medicare or Medicaid certified nursing facility, Intermediate Care Facility/Intellectual Disabilities (ICF/ID) or hospice.

Where to Report:

The Department:

- The Department's hotline number at **1-800-562-6078**. The number is available 24 hours a day, seven days a week, and the time and date of messages are recorded.

Law Enforcement:

- In an emergency, call **9-1-1** or the emergency services number.
- For non-emergency situations use the number specified by your local law enforcement authorities.

What to Report to the Department:

Individual mandated reporters must *immediately* report to the Department's hotline:

- When there is a *reasonable cause to believe* an incident is abuse, abandonment, neglect, or financial exploitation.

- o ***Reasonable cause to believe*** has also been defined as "a belief that the incident ***probably*** happened" based upon personal observation of the victim, records, other people and various other sources of relevant information. (See the definition of "reasonable cause to believe" in Appendix J, Definitions.)

- When there is a *reason to suspect* that any crime, including sexual or physical assault, has been committed against a resident of the facility.
  - o *Reason to suspect* has been defined as "a belief that the incident could ***possibly*** have happened" based upon observations and other sources of information. (See the definition of "reason to suspect" or "reasonable suspicion" in Appendix J, Definitions.)
  - o Sexual assault includes but is not limited to unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, sexual harassment, and sexual relations between a resident and a staff member.
  - o Physical assault includes the attempt to injure another person, unlawfully touching another person or action that causes fear of harm in another person. (An incidental push or gentle contact may not be an assault unless the person intended to do harm or create fear.)

What to Report to Law Enforcement:

Individual mandated reporters and covered individuals must report to law enforcement:

- When there is a reason to suspect that any crime, including sexual assault or physical assault, has been committed against a resident, except under circumstances described below.
- When there is reasonable cause to believe that an act has caused fear of imminent harm.
- Limited Exception: An incident of physical assault between residents always has to be reported to the Department, but does not have to be reported to Law Enforcement, ***unless***

  (a) it caused more than minor bodily injury ***and*** *r*equired more than basic first aid, ***or if*** the injury appears on the back, face, head, neck, chest, breasts, groin, inner thigh, buttock, genital, or anal area; there is a fracture; there is a pattern of physical assault between the same residents or involving the same residents; or there is an attempt to choke a resident, or

  (b) the injured resident or his or her legal representative or family member asks that a report be made.

What to Report to County Coroner or Medical Examiner:

- The coroner is required by law to take jurisdiction under many circumstances, including the following: sudden death of a person in good health, when circumstances indicate death by unnatural or unlawful means and death under suspicious circumstances.
- Individual mandated reporters must report the death of a resident living in a nursing home when there may have been abuse or neglect (criminal

mistreatment), or under suspicious circumstances, or other reportable circumstances**.** Refer to RCW 68.50.010 for further information.

- Once reported, and if jurisdiction is taken, your county's Coroner or Medical Examiner is responsible for investigating the cause and manner of death to decide the most appropriate death certification for that resident.

What to Report to the State Department of Health's (DOH) Disciplining Authority for License Holders:

- The nursing home must report to the Department of Health, any employee/staff person who is a health care professional, including a licensed nurse, or a registered or certified nursing assistant, against whom there are allegations involving abandonment, abuse, neglect, financial exploitation, or, misappropriation of resident property.

- The nursing home must report any information it has about an action taken by a court of law against an employee to the Department's hotline *and* to the appropriate Department of Health licensing authority, if that action would disqualify the individual from employment as described in RCW 43.43.842.

When to Make a Report:

- When an individual mandated reporter has reason to suspect that an incident is sexual or physical assault he/she must report *immediately*, as soon as the resident victim is protected from further harm.
- When an individual mandated reporter has reasonable cause to believe an incident is abandonment, abuse, neglect or financial exploitation, the report must be made *immediately*.
- If an immediate report is not required under the requirements described above, a covered individual, who has a reason to suspect that a crime has been committed against a resident in the facility, must report to the Department and to Law Enforcement (a) within two (2) hours, if there is serious bodily injury; or (b) within 24 hours, if there is not serious bodily injury.

What Should be Reported for Incidents involving Resident To Resident Altercations?

- **Report to the Department:** Requirements for reporting resident to resident assaults to the Department are the same as the reporting requirements for any incident of physical assault against a resident. See the reporting requirements under **"What to Report to the Department"**.

- **Report to Law Enforcement:**
  - Sexual assault;
  - An incident of physical assault between residents must be reported to law enforcement if it causes more than minor bodily injury ***and*** requires more than basic first aid, ***or if*** (a) the injury appears on the back, face, head, neck, chest, breasts, groin, inner thigh, buttock, genital, or anal area; (b) there is a

fracture; (c) there is a pattern of physical assault between the same residents or involving the same residents; or (d) there is an attempt to choke a resident; or

- *Any* incident of sexual or physical assault between residents must be reported if the injured resident or his or her legal representative or family member asks that a report be made.

Information to be Included in a Mandated Reporter's Report:

State law identifies that each report, oral or written, must contain as much as possible of the following information:

- The name and address of the person making the report;
- The name and address of the vulnerable adult and the name of the facility providing care;
- The name and address of the legal guardian or alternate decision maker;
- The nature and extent of the abandonment, abuse, financial exploitation, neglect or self-neglect;
- Any history of previous abandonment, abuse, financial exploitation, neglect, or self-neglect;
- The identity of the alleged perpetrator, if known, and;
- Other information that may be helpful in establishing the extent of abandonment, abuse, financial exploitation, neglect, or the cause of death of the deceased vulnerable adult. [RCW 74.34.035(8)(a)-(g)]

Mandated Reporter Identity Confidentiality:

- The identity of the person is kept confidential unless that person consents or there is a judicial proceeding. [RCW 74.34.095 (1) through (3)]

Termination, Suspension or Discipline of a Mandated Reporter:

- A mandated reporter cannot be terminated, suspended or disciplined by the employer as long as the mandated report is made in good faith. The mandated reporter may, however, be terminated, suspended, or disciplined by the employer for other lawful purposes. [RCW 74.34.180(3)]

Resident Discharge

When a resident (or others unassociated with the facility) makes a complaint on behalf of another resident or on behalf of him or herself:

- As long as the Department has substantiated the complaint, neither the resident making the complaint, nor the resident who is the subject of the complaint, may be discharged from the facility. An action, by the facility, to discharge a resident who makes a complaint or who was the subject of a complaint, substantiated by the Department within one year from the date a complaint was made, is presumed to be a retaliatory discharge and prohibited by law. The presumption that the discharge was motivated by the complaint may be disproved, and a discharge may therefore be permitted, by showing that the increased needs of the resident cannot be met by the reasonable accommodation of the facility or that the

discharge action was begun prior to the complaint having been filed. [RCW 74.34.180(1)&(2)]

- In addition to the mandated reporter requirements related to resident transfer or discharge, nursing facilities must continue to meet the federal and/or state law related to resident discharge and not discharge a resident unless those requirements are met. [42 CFR 483.12 and RCW 74.42.450]

Non-Reporting:

- A person who is required to make a report under this chapter and who knowingly fails to make the report is guilty of a gross misdemeanor. [RCW 74.34.053(1)]
- Failure to report resident abuse or neglect is a crime and may be prosecuted.
- Licensing action may be taken by the appropriate professional licensing authority based upon non-reporting, by those professionals, of incidents of suspected abuse or neglect.
- Under federal law, a covered individual who fails to report a reasonable suspicion of a crime will be subject to a civil money penalty, which could be very large. The individual could also be excluded from participating in any federally funded health care program, including a Medicare or Medicaid-funded program.

False Reporting:

- A person who intentionally makes a false report is guilty of a misdemeanor.

Reporting the Incident to the Supervisor:

- Remember that for the purposes of reporting abuse, abandonment, neglect, financial exploitation, sexual abuse and physical abuse, the person mandated to report to the Department is any nursing home employee or other mandated reporter:
  - Who observes the incident or hears the victim state it happened.
  - Hears about an incident from a permissive reporter who has direct knowledge of the incident.
- Your reporting obligation under the law is not met if you only report to your supervisor. The law states that each employee is a mandated reporter; therefore, you must make the reporting call when you have reasonable cause to believe or reason to suspect the incident is reportable. To protect the victim from further harm, a facility should have principles and procedures in place that direct staff to notify the responsible person in the facility. Procedures should tell you what you are to do if the person responsible for the incident is the person to whom you usually report.

Reporting to the Supervisor Prior to Making the Required Reporting Call:

- A facility cannot have a procedure that interferes with mandated reporting; therefore a mandated reporter must be allowed to report as required before reporting to the supervisor. However, the individual may need to consult with the

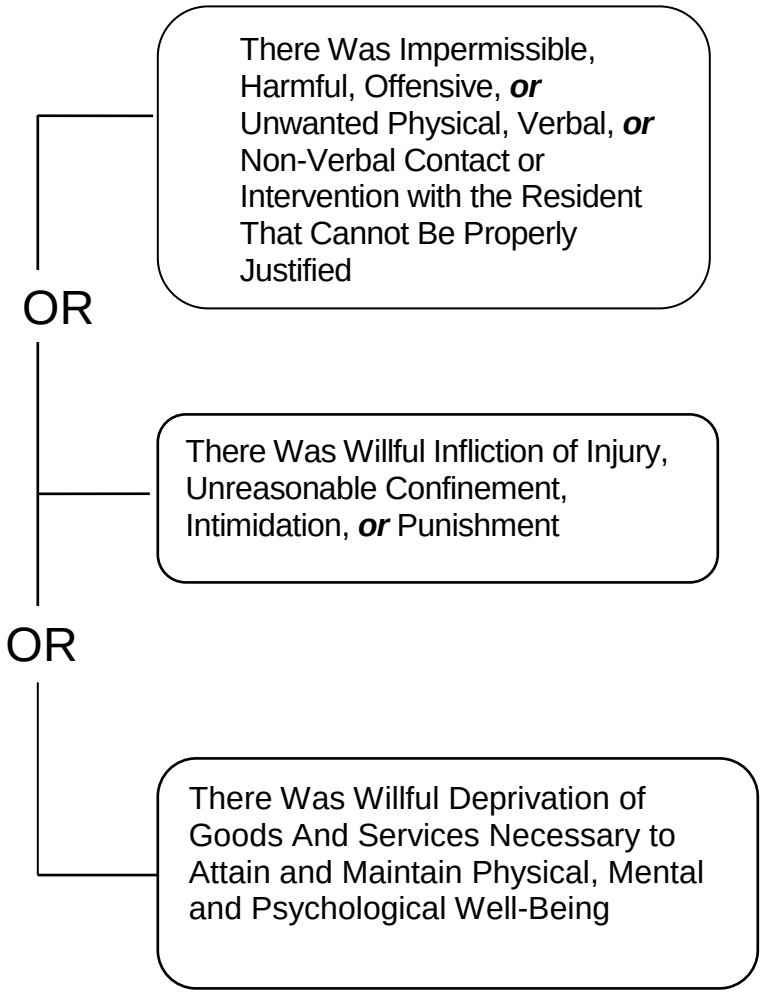
supervisor to assist in making the determination if there is a reasonable cause to believe or a reason to suspect the incident is reportable. [RCW 74.34.035(3)(6)]

Protecting the Resident from Further Harm:

- Preventing the resident from further harm means keeping the resident safe. Each situation will be different. Here are some examples of actions that might be implemented:
  - Assuring that the alleged perpetrator is kept away from the resident or other residents;
  - Having a trusted person stay with the resident;
  - Allowing the resident to stay in an area he/she feels is safe (wellness center, nurses station); or
  - Safeguarding the resident's property.

APPENDIX A

DEFINITION DIAGRAM – ABUSE



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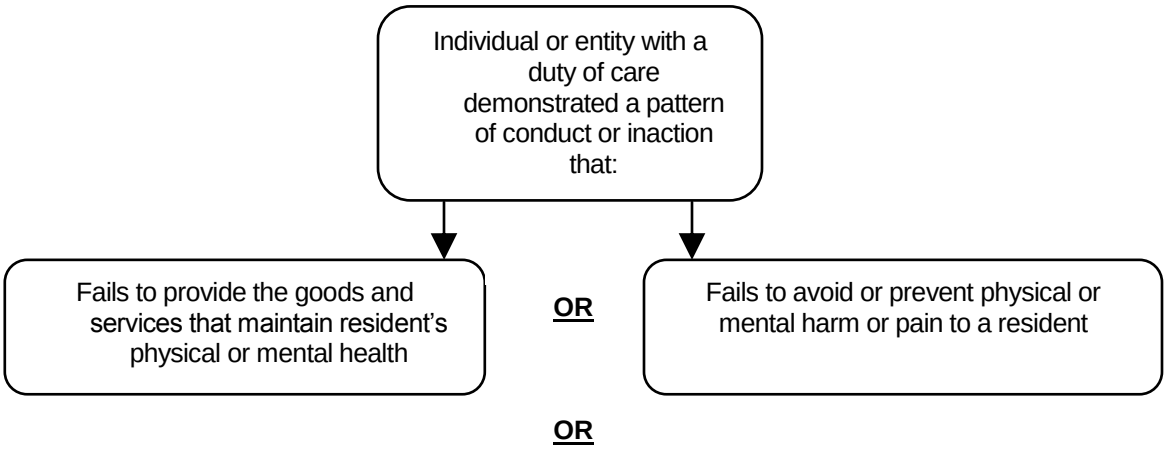
APPENDIX B

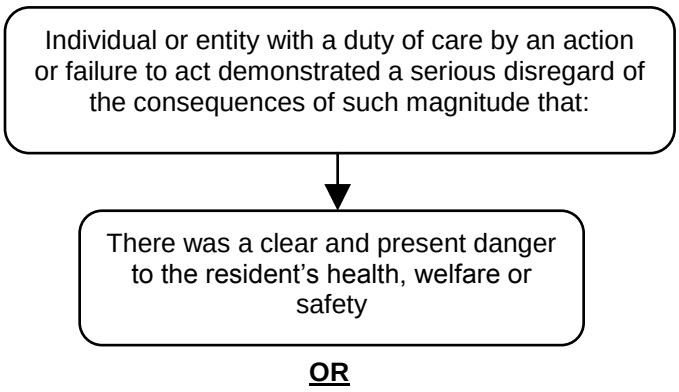
DEFINITION DIAGRAM – NEGLECT

Per state rules and federal regulations applicable to nursing homes, neglect has occurred if a, b or c below are present.

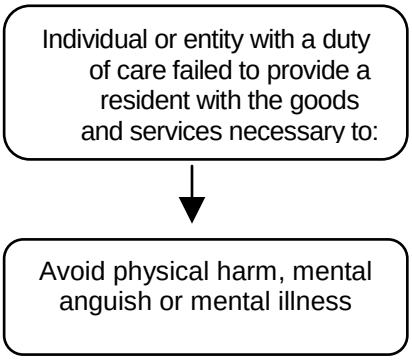
a) Neglect may result from a pattern of conduct or inaction by an individual or entity with a duty of care for nursing home residents. (Pattern means more than one occurrence) RCW 74.34.020



b) Neglect may result from a one-time act or omission by an individual or entity with a duty of care for nursing home residents. RCW 74.34.020



c) Neglect can also mean this in skilled nursing facilities or nursing facilities: 42 CFR 488.301



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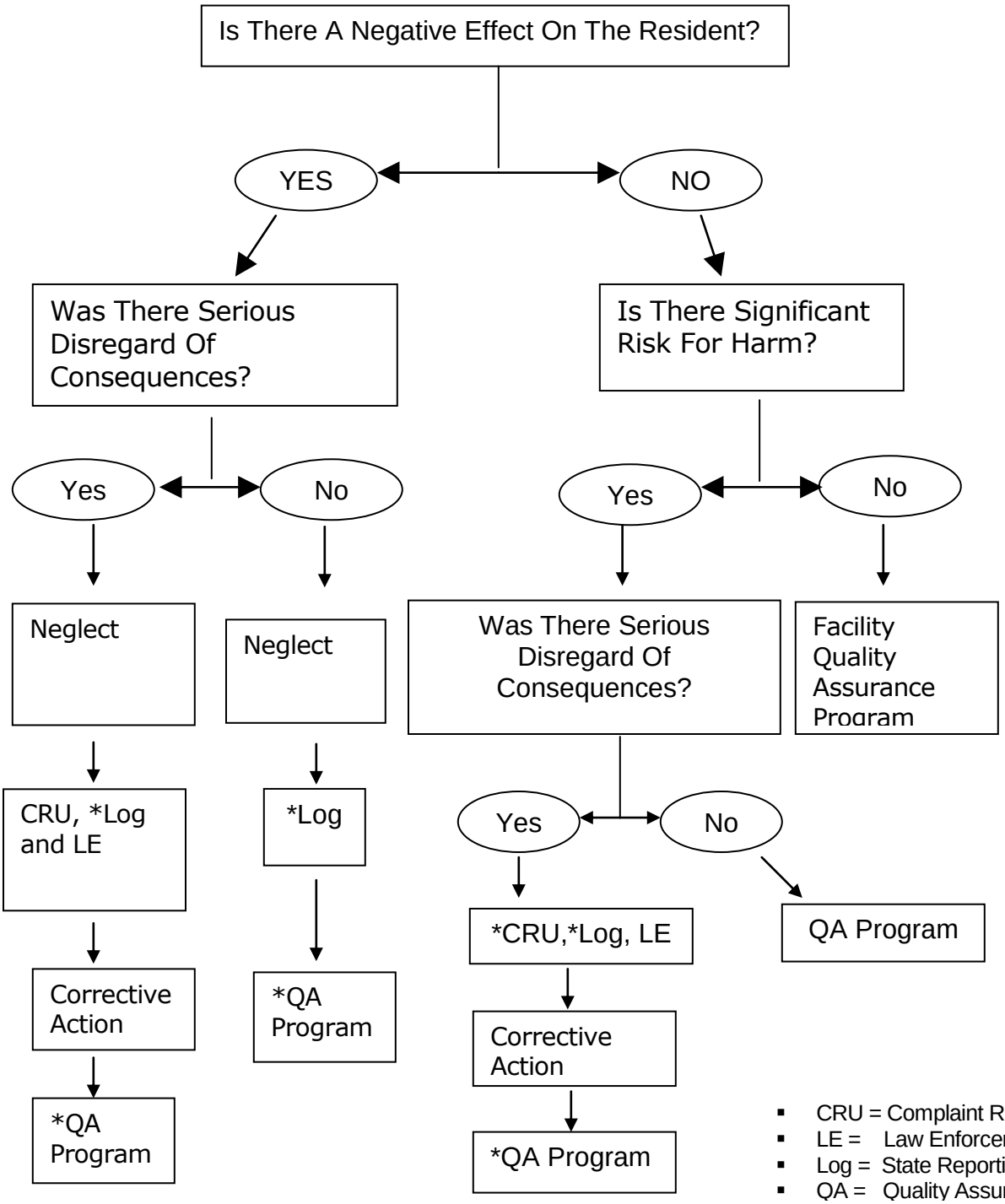
APPENDIX C

MEDICATION ERROR DECISION TREE



*It has been the long-standing practice of facilities to have a system for the review of medication errors. It is not the intent of the Department to change this system. Facilities should continue to monitor medication errors using their own internal quality assurance program. However, medication errors that *may be* abuse or neglect must be reported to the Department and to law enforcement.

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APPENDIX D
REPORTING GUIDELINES FOR NURSING HOMES

TYPE OF INCIDENT	DSHS Hotline 1-800-562-6078	DSHS Log Within 5 days	Police or 9-1-1	Coroner or Medical Examiner	Local Health Dept.	State DOH	State Fire Marshal
STAFF TO RESIDENT Abuse, neglect, mistreatment, or negligent treatment (except for medication errors – see decision tree – Appendix C) Sexual or physical abuse/assault	X	X	X			Xb	
MISAPPROPRIATION/ EXPLOITATION	X	X	X			Xb	
INJURIES OF UNKNOWN SOURCE***: (***Not*** incidents of abuse or neglect) ▪ Substantial	X	X	X*				
▪ Substantial reasonably related		X					
▪ Superficial, Unknown		Xc					
NON-STAFF TO RESIDENT ▪ Sexual or Physical Abuse/Assault, Neglect	Xa	X	X				
▪ Misappropriation/Exploitation	Xa	X	X				
RESIDENT TO RESIDENT ▪ Mental abuse with psychological harm	X	X					
▪ **Mental abuse without psychological harm****		X					
▪ Physical abuse/assault with bodily harm/injury	X	X	X				
▪ Physical abuse with psychological harm	X	X					
▪ Physical abuse without bodily or psychological harm**		X					
▪ Sexual abuse/assault	X	X	X				
▪ Misappropriation/ Exploitation	X	X	X*				

a = The call to the DSHS Hotline will meet the requirement for reporting to Adult Protective Services (APS), but the facility still may want to contact local APS office.

b = Report to the State DOH in *certain* circumstances when allegations or findings are made against licensed, certified, or registered health care worker(s).

c = Only those that are unknown after assessment.

*** =** May need to be reported to police if a crime is suspected

**** =** In general there is a presumption that abuse has occurred whenever there has been some type of impermissible, unjustifiable, harmful, offensive, or unwanted contact with a resident. This presumes that instances of abuse of any resident (whether comatose, cognizant, or not) cause physical harm, pain, or mental anguish.

***** =** Repeated injuries, even when related to condition, may become abuse or neglect if preventative measures are not taken.

APPENDIX D
REPORTING GUIDELINES FOR NURSING HOMES (continued)

TYPE OF INCIDENT	DSHS Hotline 1-800-562-6078	DSHS Log Within 5 days	Police or 9-1-1	Coroner or Medical Examiner	Local Health Dept.	State DOH	State Fire Marshal
UNEXPECTED DEATH							
▪ Possible related to abuse or neglect	**X**	**X**	**X**	**X**			
▪ Suicide	**X**	**X**	**X**	**X**			
▪ Not related to abuse/neglect but suspicious*	**X**	**X**	**X***	**X**			

***Certain** suspicious circumstances **[RCW 68.50.010]** that require reporting to the Coroner/Medical Examiner *may also* need to be reported to the police.

OTHER REPORTING REQUIREMENTS FOR NURSING HOMES

TYPE OF INCIDENT	DSHS Hotline 1-800-562-6078	DSHS Log Within 5 days	Police or 9-1-1	Coroner or Medical Examiner	Local Health Dept.	State DOH	State Fire Marshal
Evacuation	X	X					
Risk of Discontinuance of Services (such as no food, water, or care supplies)	X	X					
Transfer/Discharge Notice	Other*****						
Communicable Disease Outbreak	X	X			X		
Fire	X	X					X******
Explosion	X	X					X
Missing Resident	X	X	X				

*****Send a copy of Notice to RCS Field Manager.

*****In order to reduce overpayments, the NH must send immediate notification to any agency responsible for paying for the resident's care and services whenever the resident is relocated to a hospital or other health care facility, or the resident dies. [WAC 388-97-0160] The NH may report client readmissions to the Case Manager/Social Worker or by using the bed hold toll free number, 1-866-257-5066 (if the readmission occurs during the bed hold period).

******If there is a need to do fire reporting under WAC 212-12-025, the facility staff shall be deemed to have met their fire reporting obligations to the Washington State Fire Marshal's Office by reporting a fire immediately to the Department's Hotline at 1-800-562-6078 as soon as residents are protected.

APPENDIX E

REPORTING LOG FORM

***NATURE OF OCCURRENCE**
(Record as many as apply)

01 Fall
05 Medication error
10 Missing Person/Elopement
15 Equipment related or involved
20 Restraint related
25 Dietary related
30 Disaster/major outbreak
31 Evacuation
32 Unexpected death/suicide
35 Resident-to-resident altercation
40 Adverse reaction to medication/treatment
45 Self-inflicted injury +
50 Limb caught in bed, chair, side rail, etc.
55 Injury during handling
60 N/G tube related
65 Property (dentures, etc.)
66 Missing property
70 Other (describe)

***TYPE OF INJURY**
(Record as many as apply)

Substantial
S1 Fractures
S5 Burns
S10 Deep laceration
S15 Bruises of deep color, depth
S20 Area not generally vulnerable to trauma such as face, neck, back, chest, breasts, groin and inner thigh
S25 Other (describe)

Superficial
S30 Surface layers of skin
S35 Abrasions
S40 Lacerations
S45 Small bruises occurring in places generally vulnerable to trauma such as arms, forearms, and shins
S50 Other (describe)

S80 Psychological Harm

***FINDINGS**
(Record as many as apply)

75 Unknown origin ++

80 Origin established
81 Reasonably related to condition
85 Abuse
90 Neglect
95 Not preventable
100 Misappropriation/Exploitation
105 Abandonment

***ACTION TAKEN**
(Record as many as apply)

100 Staff training/counseling
101 Staff employment termination
105 Care plan revision
110 Adaptive equipment
115 First aid
120 Medical treatment
125 Physical plant modification
130 Procedure revision
135 No further action
140 Other (Indicate location of documentation

DATE LOGGED	***RESIDENT NAME***	***DATE/TIME OF INCIDENT***	****NATURE OF OCCURRENCE***	***INCIDENT LOCATION***	****TYPE OF INJURY***	****FINDINGS***	****ACTION***	***HOTLINE NOTIFIED YES/NO***	***BY WHOM***

***Complete categories with corresponding category number(s) as listed above.**
\+ *Self-inflicted* means the resident was the sole cause of his/her injury.
++ U*nknown origin* -The cause of the incident was not established
+++ *Origin established* – The cause of the incident was established. In establishing the source, the investigator is trying to determine the cause of the incident, not just the injury. For example, observation may establish that lacerations were caused by a fall, but what caused the fall?

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APPENDIX F – NURSING HOMES

STATE HOTLINE QUESTIONS (1-800-562-6078)

To make an official facility report, listen to the main message and then press "2". If you wish to bypass the next menu, press the number that represents the type of incident you will be reporting.

#	TYPE OF INCIDENT
1	Follow-up Call
2	Resident-to-Resident Incident
3	Staff-to-Resident Incident
4	Injury of Unknown Source
5	Resident Fall
6	Exploitation/Misappropriation of Resident Property
7	Other Types of Resident Incidents
8	Medication Error

The following standard information is required by facilities making reports to the state hotline:

ALL TYPES OF INCIDENTS:

1. Caller's first and last name:
2. Name of the facility followed by phone number;
3. The name of the resident(s) who is/are involved in the incident;
4. Identify if the doctor and responsible parties were notified of the incident
5. The resident's diagnosis
6. The resident's mental status
7. The resident's ambulatory and transfer status, or if wheelchair bound, identify if the resident self-propels and if he/she was using an assistance device
8. The date and time of the allegation, incident, or injury, **or** the date and time when the allegation, incident or injury was first discovered.
9. Identify if the care plan has changed.

In addition **to the above questions, be prepared to provide the following information when calling to report:**

FOLLOW-UP CALL – Select 1:

1. Identify the date of the initial report;
2. Identify the conclusion of the investigation;
3. Identify measures put in place to prevent a reoccurrence.

A RESIDENT-TO-RESIDENT INCIDENT – Select 2:

1. Describe the incident and any injuries;
2. Identify if the incident was sexual in nature;
3. Identify if it was witnessed and if so, by whom.
4. Identify if there was evidence of psychological harm.
5. Identify if the incident is isolated or a pattern;
6. Describe the plan to prevent further incidents.

ALLEGATION OF STAFF TO RESIDENT ABUSE OR NEGLECT – Select 3:

1. Describe the alleged incident, and any injuries;
2. Identify if the incident was sexual in nature;
3. Identify if it was witnessed and if so, by whom.
4. Identify if there was evidence of psychological harm.

5. Identify the correct spelling and name of the employee(s) including their middle initial;
6. Identify the employee's title and if a nursing assistant, if he or she is certified;
7. Identify the employee's date of hire and date of birth;
8. Identify the employee's social security number;
9. Describe the action, if any, taken with the employee, (if suspended or terminated, identify the dates);
10. Identify if the employee has had previous warnings or incidents at your facility;
11. Describe the measures taken to protect the resident during the investigation;
12. Describe measures taken to prevent reoccurrences of the incident.

AN INJURY OF UNKNOWN SOURCE – – Select 4:

1. Describe the injury, location on the body, the size, and if a bruise, describe the color;
2. Identify if the injury was sexual in nature;
3. Identify if treatment was required and if further treatment will be needed.

RESIDENT FALL – Select 5:

1. Describe other falls within the last 12 months;
2. Identify witnesses;
3. If staff involved, state their name and explain the circumstances.
4. Identify if the care plan was followed at the time of the fall;
5. Identify the action taken to prevent reoccurrences.

EXPLOITATION OR MISAPPROPRIATION OF RESIDENT PROPERTY – Select 6:

1. Describe the details of the exploitation or misappropriation of property including the dollar amount;
2. Identity if local law enforcement has been notified, if so, identify the case number;
3. Identify the alleged perpetrator and identify the person's title or relationship to the resident;
4. If an employee is involved, identify their name including the middle initial, title, date of hire, date of birth and social security number;
5. Identify the action taken to prevent reoccurrences.

OTHER TYPES OF RESIDENT INCIDENTS – Select 7:

1. Describe the injury, location on the body, the size, and if a bruise, describe the color;
2. Identify if the injury was sexual in nature;
3. Identify if treatment was required and if further treatment will be needed.
4. Identify witnesses.
5. Identify the action taken to prevent reoccurrences.

MEDICATION ERROR – Select 8:

1. Identify the correct spelling and name of employee(s) involved including their middle initial;
2. Identify the employee's title and if a nursing assistant, if he or she is certified;
3. Identify the employee's date of hire and date of birth;
4. Identify the employee's social security number;
5. Describe the action, if any, taken with the employee, (if suspended or terminated, identify the dates);
6. Identify if the employee has had previous medication error incidents at your facility;
7. Describe the medication error. Include the time and date of the medication error, the name and dosages of the medication and when it was discovered.

If you believe there is further information relevant to the incident that is not addressed in the questions outlined, please feel free to leave that information at the end of your call.

APPENDIX G

RESPONSIBILITY TABLE

This table serves as a tool to help providers in understanding responsibilities to protect, investigate, report, and prevent abuse, neglect, financial exploitation, and misappropriation of resident property.

	NURSING HOME RESPONSIBILITIES	*STATUTORY REQUIREMENTS
Protection	► Take actions to prevent occurrence of incidents and safeguard resident(s) from further incident reoccurrence ► Treat all consequent ill effects experienced by resident(s) ► Provide first aid or emergency medical attention to address any sustained injuries and/or medical/mental problems ► Implement facility administrative decisions to ensure that the suspected or accused staff person does not have unsupervised access to any resident	► Chapter 74.34 RCW Vulnerable Adult Act, ► F223, F224, F225, F226 [42 CFR 483.13 (b)(c)], F353, F385 ► WAC 388-97-0640(1), (2)(a)(b), (3)(a)-(d) ► WAC 388-97-1080 ► WAC 388-97-1260 ► WAC 388-97-1620(7)(a)
Investigation	► Protect the resident and other residents during the course of Phase I or Phase II investigation, or both ► Conduct Phase I investigation within 24 hours ► Follow up with Phase II investigation if cause and/or reasonable cause undetermined ► Document facts on incident or loss to resident, responsive steps taken by facility, and resident outcomes	► Chapter 74.34 RCW Vulnerable Adult Act, ► F225, F226 [42 CFR 483.13(c)] ► WAC 388-97-0640(6) ► WAC 388-97-1620 ► WAC 388-97-1720(1)
Reporting	► Report all suspect incidents of abuse, neglect, financial exploitation, or misappropriated property ► Notify State Hotline of allegations immediately or as soon as resident is protected ► Notify Administrator immediately of allegations ► **Notify police of suspect criminal activity ► Notify Coroner/Medical Examiner timely and accurately of resident death in *certain* circumstances ► Notify state Department of Health's *discip*lining authority about allegations or findings against employed licensed, certified, or registered staff persons in *certain* circumstances ► *Log in state reporting log abuse, neglect, superficial/ substantial injuries of unknown source, misappropriated property	► Chapter 74.34 RCW Vulnerable Adult Act, ► Chapter 68.50 RCW – Human Remains ► F225, F226 [42 CFR 483.13(c)] ► CFR 488.335 CFR 488.301 ► WAC 388-97-0640(2)(4)(5)(6)(7) ► WAC 388-97-1620(7) ► WAC 388-97-1640(1)(2) ► WAC 388-97-1820
Prevention and Corrective Action	► Resolve cause of incident, injury or loss ► Prevent re-occurrence of incident (e.g. revise plan of care, staff disciplinary action, education, training, revision of policies/procedures) ► Achieve compliance with regulations relative to any other failed facility practices identified ► Incorporate concepts learned into facility administrative decisions	► Chapter 74.34 RCW Vulnerable Adult Act, ► F225, F226 and other applicable F-tags relative to area of failed practice (42 CFR 483.13) ► CFR 488.335, CFR 488.301 ► WAC 388-97-0640 ► WAC 388-97-1760(1)

The intent of the federal and state regulations is to ensure that each resident is free from incidents of abuse, neglect, and injuries of unknown source are prevented. If such incidents occur, residents must be protected, the incidents must be identified and investigated, and, further incidents prevented as early as possible.

*****Reporting log must be kept in facility.

******The decision to call the law enforcement agency depends upon whether criminal activity is suspected and immediate action needs to be taken by the law enforcement agency. Death due to abuse, neglect, or negligent treatment is a crime. Deaths of indeterminate cause with suspected abuse, neglect, or negligence must be reported immediately to the police.

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APPENDIX H
Problem Solving Procedures for Facilities Upon Discovery of An Incident/Allegation

PROTECT * INVESTIGATE * REPORT * CORRECT * PREVENT

In general, there is presumption that abuse has occurred whenever there has been some type of impermissible, unjustifiable, harmful, offensive, or unwanted contact with a resident. This presumes that instances of abuse of any resident (whether comatose, cognizant or not) causes physical harm, pain, or mental anguish.

1. Immediately treat ill effects to resident
2. Protect resident against further occurrences
3. Institute other interventions as needed

PHASE I
1. Begin investigation upon discovery of the incident
2. Gather facts to answer who, what, when, where, how, and why
3. Analyze information to rule out or establish the likelihood that abuse, neglect, financial exploitation has occurred, or may have contributed to the incident

NOTE: Report suspected abuse, neglect, financial exploitation *immediately*
Record: **(1)** The details of the incident in the resident's medical record(s); and **(2)** The details of the investigation according to the requirements and facility protocol

a. Substantial injury seems reasonably related to: resident's condition, known & predictable interactions with surroundings, diagnoses, etc. OR a known sequence of prior events

1. Record findings that validate this conclusion
2. For substantial injuries, Log within 5 days

b. There was an unexpected, unusual, unintended event (AN ACCIDENT) which could *not* have been predicted, given prevailing circumstances

1. Record findings that validate this conclusion
2. No reporting in Log or to Hotline is necessary

c. Incident is suspected to be abuse, neglect, exploitation, or misappropriation

RESIDENT TO RESIDENT
Record details of the incident.
Report to the Department all incidents:
Of sexual abuse
That result in psychological harm to the victim
Of physical abuse that result in bodily harm to the victim;
That may show neglect on the part of the facility due to the recurrent resident-to-resident incidents.
Report to law enforcement incidents of:
Sexual abuse
Physical abuse with bodily harm
Reporting log within 5 days:
All incidents

FAMILY/VISITOR TO RESIDENT
Record details of the incident.
Report to the Department:
All incidents
Report to law enforcement:
Sexual abuse
Physical abuse with bodily harm
Misappropriation/ financial exploitation
Reporting log within 5 days:
All incidents

STAFF TO RESIDENT
Record details of the incident.
Report to the Department:
All incidents
Report to law enforcement: Sexual abuse; Physical abuse with bodily harm; Misappropriation/ financial exploitation
Reporting log within 5 days:
All incidents

d. The cause/circumstance of the incident cannot be determined in Phase I investigation

PHASE II
1. Gather additional facts
2. Analyze for likelihood of abuse / neglect /financial exploitation, or misappropriation of resident property

Cause identified: Go back to **Phase I**

e. Cause of incident still undetermined after Phase II investigation

1. Record details of investigation
2. For a Substantial injury: (a) Call Hotline and log within 5 days; (b) Contact police if crime is suspected
3. For a Superficial injury: Log within 5 days

1. Act to prevent recurrence of incident and protect resident(s), even if exact cause of incident has not been identified
2. If related to abuse/neglect/negligent treatment/misappropriation, refer to appropriate protective services
3. Do needed re-assessment, care revision, staff training and equipment modification to assure resident's safety

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APPENDIX I
REGULATIONS RELEVANT TO RESIDENT PROTECTION

The facility must become familiar with all of the federal and state rules, including any successor laws and rules, which apply to resident protection. The federal regulations are found at 42 CFR 483.13 and include a number of requirements and specific guidance around the regulatory expectations. Also, the Elder Justice Act of 2009 added requirements for the reporting of possible crimes to law enforcement. The requirements can be found in Section 1150B of the Social Security Act**.**

State law in chapter 74.34 RCW includes definitions and provisions for reporting possible abuse and neglect. The nursing home rules at WAC 388-97-0640, Prevention of Abuse, also provide the facility with direction and information about resident protection. Some links to these laws and rules will be found at the end of this appendix.

Be aware that this document includes only some portions of applicable laws and rules. It is the responsibility of the facility and mandated reporters to access the relevant laws and rules, become familiar with all of the provisions, and maintain compliance with the requirements. The following list of the federal regulations includes a brief description of the intent of each regulation. A more detailed discussion of the intent can be found in the State Operations Manual, Appendix PP – Guidance to Surveyors.

42 CFR §483.13: Resident Behavior and Facility Practices

(a) Restraints – The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. **INTENT:** Each resident has the right to attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints.

(b) Abuse – The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. **INTENT**: Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.

(c) Staff Treatment of Residents – The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.
(c)(1)(i) The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. **INTENT**(c)(1)(i)**:** Each resident has the right to be free from mistreatment, neglect and misappropriation of property. This includes the facility's identification of residents whose personal histories render them at risk for abusing other residents, and the development of intervention strategies to prevent occurrences, monitoring for changes that would trigger abusive behavior, and reassessment of the interventions on a regular basis.

(c)(1)(ii) Not employ individuals who have been –(A) Found guilty of abusing, neglecting or mistreating residents by a court of law; or (B) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and,

(c)(1)(iii) Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

INTENT: (c)(1)(ii and iii): The facility must develop and operationalize policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences. Also, the facility must not hire a potential employee with a history of abuse, if that information is known to the facility. The facility must report knowledge of actions by a court of law against an employee that indicated the employee is unfit for duty. The facility must report alleged violations, conduct an investigation of all alleged violations, and take necessary corrective actions.

(c)(2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported *immediately* to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

(c)(3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

(c)(4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

REPORTING TO LAW ENFORCEMENT OF CRIMES OCCURRING IN FEDERALLY FUNDED LONG-TERM CARE FACILITIES

Section 6703(b)(3) LONG-TERM CARE FACILITIES.—Part A of title XI of the **Social Security Act** (42 U.S.C. 1301 et seq.), as amended by section 6005, is amended by inserting after section 1150A the following new section: **SEC. 1150B . . .**

(b) REPORTING REQUIREMENTS.—

(1) IN GENERAL.—Each covered individual shall report to the Secretary and 1 or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime (as defined by the law of the applicable political subdivision) against any individual who is a resident of, or is receiving care from, the facility.

(2) TIMING.—If the events that cause the suspicion—

(A) result in serious bodily injury, the individual shall report the suspicion *immediately*, but not later than 2 hours after forming the suspicion; and
(B) do not result in serious bodily injury, the individual shall report the suspicion not later than 24 hours after forming the suspicion.

. . .

(d) ADDITIONAL PENALTIES FOR RETALIATION.—

(1) IN GENERAL.—A long-term care facility may not—

(A) discharge, demote, suspend, threaten, harass, or deny a promotion or other employment-related benefit to an employee, or in any other manner discriminate against an employee in the terms and conditions of employment because of lawful acts done by the employee; or

(B) file a complaint or a report against a nurse or other employee with the appropriate State professional disciplinary agency because of lawful acts done by the nurse or employee, for making a report, causing a report to be made, or for taking steps in furtherance of making a report pursuant to subsection (b)(1).

RCW 74.34.035(1–7): Reports – Mandated and permissive

(1) When there is reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, mandated reporters shall *immediately* report to the Department.

(2) When there is reason to suspect that sexual assault has occurred, mandated reporters shall *immediately* report to the appropriate law enforcement agency and to the Department.

(3) When there is reason to suspect that physical assault has occurred or there is reasonable cause to believe that an act has caused fear of imminent harm:

(a) Mandated reporters shall *immediately* report to the Department; and

(b) Mandated reporters shall *immediately* report to the appropriate law enforcement agency, except as provided in subsection (4) of this section.

(4) A mandated reporter is not required to report to a law enforcement agency, unless requested by the injured vulnerable adult or his or her legal representative or family member, an incident of physical assault between vulnerable adults that causes minor bodily injury and does not require more than basic first aid, unless:

(a) The injury appears on the back, face, head, neck, chest, breasts, groin, inner thigh, buttock, genital, or anal area;

(b) There is a fracture;

(c) There is a pattern of physical assault between the same vulnerable adults or involving the same vulnerable adults; or

(d) There is an attempt to choke a vulnerable adult.

(5) When there is reason to suspect that the death of a vulnerable adult was caused by abuse, neglect, or abandonment by another person, mandated reporters shall, pursuant to RCW 68.50.020, report the death to the medical examiner or coroner having jurisdiction, as well as the Department and local law enforcement, in the most expeditious manner possible. A mandated reporter is not relieved from the reporting requirement provisions of this subsection by the existence of a previously signed death certificate. If abuse, neglect, or abandonment caused or contributed to the death of a vulnerable adult, the death is a death caused by unnatural or unlawful means, and the

body shall be the jurisdiction of the coroner or medical examiner pursuant to RCW 68.50.010.

(6) Permissive reporters may report to the Department or a law enforcement agency when there is reasonable cause to believe that a vulnerable adult is being or has been abandoned, abused, financially exploited, or neglected.

(7) No facility, as defined by this chapter, agency licensed or required to be licensed under chapter 70.127 RCW, or facility or agency under contract with the Department to provide care for vulnerable adults may develop policies or procedures that interfere with the reporting requirements of this chapter.

Other Applicable Nursing Home Statutes/Rules

These guidelines may refer to portions of other regulatory requirements applicable to nursing homes to assist them in promoting the safety and well-being of their residents. Some applicable laws and rules are listed below.

The Online Version of these Guidelines Provides Hyperlinks to these Selected Regulations:

- Chapter 18.51 RCW – Nursing Homes
- Chapter 43.43 RCW – Washington State Patrol – Criminal Background Checks
- Chapter 68.50 RCW – Human Remains
- Chapter 70.129 RCW – Long-Term Care Resident Rights
- Chapter 74.34 RCW – Abuse of Vulnerable Adults
- Chapter 388-97 WAC – Nursing Home Licensing Rules

APPENDIX J
DEFINITIONS

This appendix contains the definitions of the most frequently used words in the process of nursing home abuse/neglect identification, reporting, and investigation. Also included are various guidelines and comments. Examples correlating to the definitions are provided. These examples ***should not*** be considered all-inclusive, nor are they mutually exclusive. It also contains both legal references and state and federal guidelines.

Definitions	Guidelines & Comments	Examples
"ABANDONMENT" as defined in RCW 74.34.020(1) means an action or inaction by a person or entity with a duty of care for a vulnerable adult that leaves the vulnerable person without the means or ability to obtain necessary food, clothing, shelter, or health care.	RCW 74.34.205 Abandonment, abuse or neglect - Exceptions (1) Any vulnerable adult who relies upon and is being provided spiritual treatment in lieu of medical treatment in accordance with the tenets and practices of a well-recognized religious denomination may not for that reason alone be considered abandoned, abused, or neglected. (2) Any vulnerable adult may not be considered abandoned, abused, or neglected under this chapter by any health care provider, facility, facility employee, agency, agency employee, or individual provider who participates in good faith in the withholding or withdrawing of life-sustaining treatment from a vulnerable adult under chapter 70.122 RCW, or who acts in accordance with chapter 7.70 RCW or other state laws to withhold or withdraw treatment, goods, or services.	**NOTE:** Leaving a resident at a hospital emergency room (ER) is ***not*** considered an act of abandonment.
"ABUSE" as defined in 42 CFR 488.301, means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish.	The obligation of nursing homes is to protect the health and safety of every resident, including those that are incapable of perception or who are unable to express themselves. In general, you must presume that abuse has occurred whenever there has been some type of impermissible, unjustifiable, harmful, offensive or unwanted contact with a NH resident.	

Definitions	Guidelines & Comments	Examples
"ABUSE" (continued) The federal interpretive guidelines for 42 CFR 483.13(b) and (c) in the State Operations Manual also include the definition of abuse, the willful deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. **"ABUSE"** as defined in RCW 74.34.020(2) means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. See also Appendix A for Abuse Definition Diagram. A variety of actions fall within the definitions of abuse. An action can be abusive even if there is no intent to cause harm.	This means that instances of abuse of any resident (whether comatose, cognizant (aware) or not, cause physical harm or pain or mental anguish. The term "willful" describes the deliberate or non-accidental action or inaction that resulted in the abuse of the resident. The term "willful" does not mean that an individual intended to cause harm, pain, anguish or injury. Instead, "willful" means that the individual intended the action or inaction itself that he/she knew or should have known could cause one or more negative outcomes to nursing home resident(s), including harm, anguish, pain or injury. Willful inaction includes, but is not limited to, a nursing home staff member's refusal to provide the necessary care and required services, or, intentional deprivation of a resident, or both. Emergency or short-term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident's needs. Refer also to the federal interpretive guidelines for 42 CFR 483.13(b) and (c) in the State Operations Manual for further guidelines related to involuntary seclusion.	**EXAMPLES OF ABUSE** may include but are not limited to the following: ▪ **Involuntary Seclusion:** Separation of a resident from other residents or from his/her room (with or without roommates) or in an isolated location against the resident's will, or will of the resident's legal representative.

Definitions	Guidelines & Comments	Examples
"ABUSE" includes exploitation, mental (verbal) abuse, physical abuse, and sexual abuse of a vulnerable adult, which have the following meanings: ▪ **ABUSE – EXPLOITATION" as defined in RCW 74.34.020(2)(d)** means an act of forcing, compelling, or exerting undue influence over a vulnerable adult causing the vulnerable adult to act in a way that is inconsistent with relevant past behavior, or causing the vulnerable adult to perform services for the benefit of another. See also the definition of "**Misappropriation of Resident Property**" and "**Financial Exploitation**". In some situations, these terms may be used interchangeably.	In addition to theft or outright taking of resident property, exploitation may involve tricking the resident into signing a document or giving consent regarding matters involving property or finances through the use of manipulation, deception or keeping the vulnerable adult ignorant of important facts about their money, property, or other resources. Comprised mental or physical capacity may make a resident more susceptible to deception, undue influence, or pressure.	**Exploitation:** may include, but are not limited to, the following: ▪ Any individual who sells the resident's property, house, or other valuables for their own personal gain or profit; ▪ Surrogate decision maker or payee who has been given fiduciary responsibility by the resident to pay the nursing home bill, is refusing to meet the resident's needs by using the resident's money or asset for his or her personal profit or gain; ▪ Any individual who for personal profit or advantage coerces the resident to sign a document, contract, legal form, or any other form designating authority over the resident's finances and property; ▪ Surrogate decision maker or payee does not pay into the resident's trust fund account and does not provide for the resident's personal needs, but uses the money to buy their own items or pay personal bills. ▪ **Review Appendix K** – Key Triggers/Possible Criminal Indicators for other examples of **Exploitation / Financial Exploitation.**

Definitions	Guidelines & Comments	Examples
▪ **ABUSE – MENTAL" as defined in RCW 74.34.020(2)(c)** means any willful action or inaction of mental or verbal abuse. **Mental abuse includes, but is not limited to, coercion, harassment, inappropriately isolating a vulnerable adult from family**, friends, or regular activity, and verbal assault that includes ridiculing, intimidating, yelling, or swearing.	**Mental Abuse:** humiliation, harassment, threats of punishment or deprivation, purposely withholding cigarettes or some form of entertainment, or something that is rightfully the resident's, or placing any unreasonable restrictions on the resident's mobility or ability to communicate with other persons either verbally or in writing. **Verbal Abuse:** Any use of oral, written or gestured language that willfully includes threats and/or disparaging & derogatory terms to or about residents or their families, within hearing distance of any resident regardless of their age, ability to comprehend, or disability; threats of harm; saying things to frighten a resident, such as telling a resident that she will never be able to see her family again.	▪ **Review Appendix K** – Key Triggers / Possible Criminal Indicators for other examples of **Mental or Verbal Abuse.**
▪ **"ABUSE – PHYSICAL" as defined in RCW 74.34.020(2)(b)** means the willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to striking with or without an object, slapping, pinching, choking, kicking, shoving, prodding, or the use of chemical restraints or physical restraints unless the restraints are consistent with licensing requirements, and includes restraints that are otherwise being used inappropriately.	Physical contact with a resident for the purpose of retaliating against that resident, even in response to a physical attack or verbal abuse from a resident, is never justifiable and constitutes abuse. A variety of actions fall within the definition of abuse. An action can be abusive even if there is no intent to cause harm. Assault is a crime and requires intent to cause harm. As used in these guidelines, an assault is always abuse, but some abusive actions may not amount to an assault.	▪ **Review Appendix K** – Key Triggers / Possible Criminal Indicators for other examples of **Physical Abuse.** ▪ **Physical Abuse:** Hitting, slapping, prodding, poking, or sticking a resident with a sharp object, pushing, shoving, spitting, twisting, squeezing, pinching, and kicking. It also includes controlling behavior through corporal punishment, such as purposely withholding food and medications.

Definitions	Guidelines & Comments	Examples
▪ **"ABUSE – SEXUAL" as defined in RCW 74.34.020 (2)(a)** means any form of non-consensual contact, including but not limited to, unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. Sexual abuse includes any sexual contact between a staff person, who is not also a resident or client, of a facility or a staff person of a program authorized under chapter 71A.12 RCW, and a vulnerable adult living in that facility or receiving services from a program authorized under chapter 71A.12 RCW, whether or not it is consensual.		▪ **Review Appendix K** – Key Triggers / Possible Criminal Indicators for other examples of **Sexual Abuse.** ▪ **Sexual Abuse:** Inappropriate touching, sexual harassment, sexual coercion, or sexual assault. ▪ **Sexual Contact:** May include interactions that do not involve touching including, but not limited to, sending sexually explicit messages, or cueing or encouraging a resident to perform sexual acts.
"ACCIDENT" as defined in 42 CFR 483.25(h), in the State Operations Manual is any unexpected or unintended incident, which may result in injury or illness to a resident.	Foreseeable incidents are ***not*** unavoidable accidents. 42 CFR 483.10(b)(11) and WAC 388-97-0320(1) require that nursing homes immediately inform the resident; consult with the resident's physician; and if known, notify the resident's surrogate decision maker when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention. 42 CFR 483.25(h) states that the facility must ensure that the resident environment remains as free of accident hazards as possible and that each resident receives adequate supervision and assistance devices to prevent accidents. Accidents do include equipment or mechanical failures that were not known prior to the use of the equipment. Routine preventative maintenance is important to prevent accidents.	**EXAMPLES OF ACCIDENTS** may include, but are not limited to, the following: ▪ A self-propelling resident catches a finger in her wheelchair spoke and fractures the finger. ▪ An independent resident who becomes dizzy fails to use call light for help and falls while getting out of bed. ▪ Resident pinches hand in doorjamb and sustains a skin tear. ▪ Resident hits arm on the head of the bed and sustains a bruise on forearm. Any of the above examples *may* become examples of neglect if repeated without facility intervention, or if the prior risk of such an event was identified and no action was taken to prevent the occurrence.

Definitions	Guidelines & Comments	Examples
"BODILY HARM" as defined in RCW 9A.04.110(4)(a) means physical pain or injury, illness or an impairment of physical condition. In RCW 9A.04.110(4)(b) **"Substantial bodily harm"** means bodily injury which involves a temporary but substantial disfigurement, or which causes a temporary but substantial loss or impairment of the function of any bodily part or organ, or which causes a fracture of any bodily part. In RCW 9A.04.110 (4)(c) **"Great bodily harm"** means bodily injury which creates a probability of death, or which causes significant serious permanent disfigurement, or which causes a significant permanent loss or impairment of the function of any bodily part or organ.	A resident can sustain ***bodily injury*** as a result of an accident over which the facility had no control (i.e., an unavoidable accident).	**NOTE:** Not all incidents in a facility, regardless of outcome to a resident, are necessarily due to facility noncompliance with federal or state nursing home regulations. Resident was seen by NH staff to fall Friday evening, resulting in a very swollen, bruised ankle and foot, with persistent complaints of pain throughout the entire weekend. The resident's physician was not notified until Monday afternoon when orders for x-rays showed a serious ankle fracture with loose bone chips that required hospitalization for surgery and follow-up care. Second and third burns to a resident's face, chest and legs due to smoking unsupervised while using medical oxygen, contrary to the most recent assessment & comprehensive care plan identifying the need for direct supervision by NH staff at all times whenever the resident smoked.
"COVERED INDIVIDUAL" is defined in section 1150B(a)(3) of the Social Security Act as anyone who is an owner, operator, employee, manager, agent or contractor of a Medicare or Medicaid certified nursing facility, ICF/ID, or hospice. For individuals and entities affiliated nursing facilities, this term is similar to the definition of "mandated reporter", except that "covered individual" also includes facility owners.	Section 1150B is a section of the Social Security Act that requires the reporting of any reasonable suspicion of a crime committed against a resident of, or an individual receiving care from, a long-term care facility**.** These reports must be submitted to at least one law enforcement agency of jurisdiction and the State Survey Agency (SA) per the provisions in section 6703 of the Affordable Care Act of 2010, part of the Elder Justice Act of 2009.	

Definitions	Guidelines & Comments	Examples
"COVERED INDIVIDUAL" (Continued) [The facility reporting requirement stems from federal law, not RCW 74.34. WAC 388-97, which was adopted to comply with federal law, also includes a facility reporting requirement.] **See also the definition of "MANDATED REPORTER". In some situations these terms may be used interchangeably.**	Section 1150B (d) of the Act also prohibits a long-term care facility from retaliating against any "covered individual" who makes such a report. **"Covered Individuals"** who fail to report under Section 1150B (b) of the Act shall be subject to various penalties, including civil monetary penalties.	
"EXCLUDED INDIVIDUAL" means a covered individual who has been determined by the federal government to be excluded from participation in any Federal health care program (as defined in section 1128B(f) of the Act) under sections 1150B(c)(1)(B) or 1150B(c)(2)(B) of the Act; due to failure to meet the reporting requirements of this provision.		
"EXCLUDED ENTITY" means a long term care facility that been determined by the federal government under section 1150B(d)(2) of the Act to be excluded for a period of 2 years pursuant to section 1128(b) of the Act.	**CMS** has determined that if a long-term care facility employs any "covered individual" who has been ***excluded*** from participating in any Federal health care program, then the **facility** will be ineligible to receive Federal funds under the Act.	
"CRIME" as referenced in Section 1150B(b)(1) of the Social Security Act provides that a "crime" is defined by law of the applicable political subdivision where a long-term care facility is located. **See also the definitions of "BODILY HARM" related to *certain* criminal offenses.**	Federal law requires nursing facilities to coordinate with their local law enforcement entities to determine what actions are considered crimes within their political subdivision. **NOTE:** RCW Title 9A is known as the Washington Criminal Code.	In *certain* cases, neglect may be the ***crime*** of Criminal Mistreatment per RCW 9A.42.020-037.

Definitions	Guidelines & Comments	Examples
"FINANCIAL EXPLOITATION" as defined in RCW 74.34.020(6)(a)(b)(c) means the illegal or improper use, control over, or withholding of the property, income, resources, or trust funds of the vulnerable adult by any person or entity for any person's or entity's profit or advantage other than for the vulnerable adult's profit or advantage. "Financial exploitation" includes, but is not limited to: (a) The use of deception, intimidation, or undue influence by a person or entity in a position of trust and confidence with a vulnerable adult to obtain or use the property, income, resources, or trust funds of the vulnerable adult for the benefit of a person or entity other than the vulnerable adult; (b) The breach of a fiduciary duty, including, but not limited to, the misuse of a power of attorney, trust, or a guardianship appointment, that results in the unauthorized appropriation, sale, or transfer of the property, income, resources, or trust funds of the vulnerable adult for the benefit of a person or entity other than the vulnerable adult; or (c) Obtaining or using a vulnerable adult's property, income, resources, or trust funds without lawful authority, by a person or entity who knows or clearly should know that the vulnerable adult lacks the capacity to consent to the release or use of his or her property, income, resources, or trust funds.	Others may financially exploit a resident for personal gain or profit by breach of fiduciary duty, deception, and intimidation of undue influence. **Financial exploitation acts** may include, but are not limited to, the following: ▪ Identity theft (RCW 9.35.020); ▪ Theft by taking, deception, embezzlement (RCW 9A.56 (030-050); ▪ Forgery (RCW 9A.60(020-060); ▪ Undue influence, coercion and fraud; ▪ Abuse of Trust: powers of attorney or legal guardianships	▪ **Review Appendix K** – Key Triggers / Possible Criminal Indicators for other examples of **Exploitation / Financial Exploitation.** ▪ Scams

Definitions	Guidelines & Comments	Examples
See also definitions of "MISAPPROPRIATION OF RESIDENT PROPERTY" and "ABUSE – EXPLOITATION". In some situations these terms may be used interchangeably.		
"INCIDENT" For the purposes of these guidelines, an incident means: An occurrence involving a resident in which mistreatment, neglect, abuse, misappropriation of resident property or financial exploitation are alleged or suspected; or A substantial injury of unknown source, or cause, or circumstance.	All incidents require thorough investigation and reporting, as necessary, according to state and federal regulations. All such investigations attempt to determine if such injury results from abuse or neglect*. It may not always be possible to determine the cause of the incident.* The purpose of adding the definition of "*incident*" to these guidelines is to assist in identifying when a facility must do a thorough investigation. Not all occurrences that happen to residents are incidents that require an investigation. For example, superficial injuries of unknown source and some falls when ***abuse or neglect is not alleged or suspected***, do not require a thorough investigation, but do require assessment to assist in preventing reoccurrence. An ***allegation*** is a statement or a gesture made by someone (regardless of capacity or decision-making ability) that indicates that abuse, neglect, financial exploitation, or misappropriation of resident property may have occurred and requires a thorough investigation.	**EXAMPLES OF INCIDENTS** may include, but are not limited to, the following: Any occurrence that is not consistent with standards of care and practice; Substantial injury of unknown source; Any allegation of mistreatment, neglect or abuse; *and* Any misappropriation of resident property or financial exploitation of a resident.

Definitions	Guidelines & Comments	Examples
	To **"*suspect"*** means to have reason to believe without conclusive proof that someone may have abused, neglected, financially exploited a resident, or misappropriated a resident's property. Documentation of the investigation for all incidents and the determination of "reasonably related" must be kept and be readily available for state review, internal risk management, and federal authorities.	
"INJURIES OF UNKNOWN SOURCE" means any injury sustained by a resident where the source of the injury was: ▪ Not observed directly by a staff person; or ▪ Not identified through the process of assessment for a superficial injury; or ▪ Not identified through the process of a thorough investigation for a substantial injury; or ▪ Determined not to be reasonably related to the resident's condition, diagnosis, known and predictable interaction with surroundings or related to a known sequence of prior events. Injuries of unknown source may be either **superficial** or **substantial** in nature.	It is not always possible to determine the cause of the injury. **Types of injuries of unknown source**: **SUPERFICIAL INJURIES** of unknown source include injuries limited to the surface layers of the skin, easily treated with first aid/not requiring physician's orders for treatment (such as sutures or diagnostic x-rays); **and** located in areas generally vulnerable to trauma. Superficial injuries of unknown source that are not incidents of suspected or alleged abuse or neglect must be assessed to determine the cause and appropriate corrective action must be taken. Documentation of the assessment must be in the resident's clinical record. **SUBSTANTIAL INJURIES** of unknown source include injuries that are more than superficial. Substantial injuries require more than first aid and may require close assessment and monitoring by nursing or medical staff. They also include injuries occurring in areas not generally vulnerable to trauma.	**EXAMPLES of SUPERFICIAL INJURIES** may include, but are not limited to, the following: ▪ Small abrasions, lacerations, or bruises limited to the surface layers of the skin, occurring in areas generally vulnerable to trauma, such as hands, forearms, and shins. **EXAMPLES of SUBSTANTIAL INJURIES** may include, but are not limited to, the following: ▪ Abrasions, burns, deep lacerations, bruises of deep color and depth, or those occurring in areas not generally vulnerable to trauma, such as the back, face, head, neck, chest,

Definitions	Guidelines & Comments	Examples
"INJURIES OF UNKNOWN SOURCE" (Continued)	Substantial injuries of unknown source, even if they do not appear to be due to abuse or neglect, **must** be reported to the Department; because the injuries may have resulted from the failure to take preventative measures. ▪ ***ALL*** substantial injuries of unknown source must be thoroughly investigated. ▪ ***ALL*** injuries (regardless of the extent) occurring in non-vulnerable areas of the body will be considered substantial injuries.	▪ breasts, groin, inner thigh, buttock, genital, or anal area; ▪ All fractures
"LAW ENFORCEMENT" could include the full range of potential responders to elder abuse, neglect, and exploitation including: police, sheriffs, detectives, public safety officers; corrections personnel; prosecutors; medical examiners; investigators; and coroners.	Unless directed otherwise, in an **emergency**, call **9-1-1** or your county's emergency services number. For **non-emergency** situations, use the local number specified by your local law enforcement authorities. Nursing homes are advised to *pre-determine* the non-emergency phone numbers of city, county or state police, sheriff and other law enforcement agencies**.** Each nursing home is advised to *pre-determine* the phone number of your county's coroner or medical examiner so that notification of the death of a resident, coming under their potential/actual jurisdiction, as set forth in RCW 68.50.010, can be made as expeditiously as possible. In certain circumstances, the death of a nursing home resident needs to be reported to: **1)** County Coroner or Medical Examiner, ***and*** **2)** Local law enforcement, ***and,*** 3) Department's Hotline at **1-800-562-6078.**	

Definitions	Guidelines & Comments	Examples
"MANDATED REPORTER" as defined in RCW 74.34.020(11) is an employee of the Department; law enforcement; social worker; professional school personnel; individual provider; **an employee of a facility; an operator of a facility**; an employee of a social service, welfare, mental health, adult day health, adult day care, home health, home care, or hospice agency; county coroner or medical examiner; Christian Science practitioner; or health care provider subject to Chapter 18.130 RCW. **See also the definition of "COVERED INDIVIDUAL". In some situations these terms may be used interchangeably.**	For the purpose of the definition of **mandated reporter: "Facility"** includes but is not limited any home, place or institution licensed or required to be licensed under chapter 18.51 RCW – Nursing Homes.	Therefore, any licensee, manager, employee, and contractor associated with a licensed nursing facility or a skilled facility in Washington state is an individual mandated to report abandonment, exploitation, mental/verbal abuse, physical abuse, sexual abuse, neglect, potential criminal mistreatment, financial exploitation, misappropriation of resident property, and injuries of unknown source.
"MISAPPROPRIATION OF RESIDENT PROPERTY" as defined in 42 CFR 488.301 means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. **See also the definition of "ABUSE – EXPLOITATION" and "FINANCIAL EXPLOITATION". In some situations these terms may be used interchangeably.**	**Refer also to 42 CFR 483.13(c) in the State Operations Manual for further guidelines.** Residents with cognitive impairments that are known to misplace/take another resident's belongings as part of their regular behavior are not considered to be misappropriating other resident's items.	**EXAMPLES OF MISAPPROPRIATION OF RESIDENT PROPERTY** may include, but are not limited to, the following: ▪ Facility staff or others take resident money or property without permission of the resident; ▪ Facility staff or others "borrow" clothing or other property of one resident to lend to another resident (this behavior could range from improper use of resident clothing to lending a resident's TV or wheelchair to another resident); ▪ Facility staff uses disposable briefs or gloves, or other expendable items by, or charged to a resident for another resident's use.

Definitions	Guidelines & Comments	Examples
NEGLECT" as defined in 42 CFR 488.301 means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. **"NEGLECT,"** as defined in RCW 74.34.020(12), means: (a) a pattern of conduct or inaction by a person or entity with a duty of care to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that avoids or prevents physical or mental harm or pain to a vulnerable adult; or (b) an act or omission that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety, including but not limited to conduct prohibited under RCW 9A.42.100. As referenced in RCW 74.34.020(12)(b), RCW 9A.42.100 explains the felony crime of Endangerment with a Controlled Substance (Methamphetamine). **See also Appendix B for Neglect Definition Diagram and Appendix C for Medication Error Decision Tree.**	In *certain* cases, neglect may be the ***crime*** of Criminal Mistreatment under RCW 9A.42.020-037. In the definition of neglect, the words **"necessary to avoid physical harm, mental anguish, or mental illness"** mean that it is more probable than not that harm could happen to the resident because the goods or service were not provided. Neglect may be determined even if no apparent negative outcome has occurred. Federal guidelines indicate that neglect may include instances where no apparent negative outcome has occurred, but the likelihood for deterioration of the resident's physical, mental, or emotional condition exists. The likelihood for negative outcome must be considered. For example, a staff member who fails to administer a resident's afternoon nourishment has failed to provide goods. However, one would need to consider the resident's condition before a determination could be made if this one time omission would "likely" result in harm to the resident. Neglect does ***not*** include failure to provide treatment or service that a resident has, with consent, refused. In addition, the definition of "neglect" does ***not*** include the element of intent to do harm by a provider or caregiver.	▪ Allowing the physical environment to deteriorate to the point that residents are subject to hazardous situations, such as electrical, water, and structural hazards ▪ Failure to transfer a resident in need of emergency help out of the facility when the resident's condition clearly warrants the transfer and the resident's health, safety or welfare is dependent upon emergency intervention; ▪ Failure to consult with a resident's attending physician when resident's condition requires medical intervention; ▪ Failure to assess and evaluate a resident's status or failure to institute nursing interventions as required by the resident's condition which results in harm to the resident or demonstrates a clear and present danger for harm; ▪ Failure to provide an adequate number of nutritionally balanced, properly prepared and medically appropriate meals which can or does result in weight loss patterns or other parameters of poor nutritional status that are not the result of a medical condition. ▪ **Review Appendix K** – Key Triggers / Possible Criminal Indicators for other examples of **Neglect**.

Definitions	Guidelines & Comments	Examples
"NEGLECT" (Continued)	In general, neglect occurs with the failure of the facility or an individual to follow accepted standards of practice in accordance with the facility's or staff person's relevant knowledge base or training, which leads to harm or is known to cause harm to the resident. **NOTE:** Neglect can be an investigative action finding even if no apparent outcome has occurred, but the likelihood for deterioration of the resident's physical, emotional and psychosocial well-being exists. **"Serious disregard of consequences"** means that the facility or individual actually had knowledge, or should have known (based on training or educational background), that the act committed or omitted was a clear and present danger to the resident's health, welfare, or safety; or that the act was committed or omitted with reckless disregard of its clearly dangerous consequences.	
"**PERMISSIVE REPORTER"** as defined in RCW 74.34.020(13) means any person, employee of a financial institution, attorney, or volunteer in a facility or program providing services for vulnerable adults.	**PERMISSIVE REPORTERS** may include but are not limited to, the following: ▪ Family members; ▪ Visitors; ▪ Bank Tellers; ▪ Postal Employees; ▪ Church ministers	
"REASONABLE CAUSE TO BELIEVE" means a mandated reporter thinks it is ***probable*** that an incident of abuse, abandonment, neglect, or financial exploitation happened.	RCW 74.34.035 requires a mandated reporter to: **Report *immediately* to the Department when there is:** A reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred.	**EXAMPLES OF REASONABLE CAUSE TO BELIEVE** may include, but are not limited to, the following: ▪ Finger or slap marks on a resident; ▪ A resident without a history of making allegations of abuse states that a staff member has abused her or treated her poorly;

Definitions	Guidelines & Comments	Examples
"REASONABLE CAUSE TO BELIEVE" (Continued) **Probable** means that based on information or evidence readily obtained from various sources, it is likely the incident occurred. Sources of information may include: ▪ Personal observation of the incident; ▪ The resident who is subject of incident; ▪ Incident logs, medical records, etc.; ▪ Other persons who may have relevant information A reporter may rely upon one or more of the above sources.	Federal law requires the facility to report all allegations of abuse or neglect. This would include taking seriously any allegation from residents or others with a history of making allegations.	▪ A resident demonstrates fear in the presence of a particular caregiver or other people.
"REASON TO SUSPECT" or "REASONABLE SUSPICION" means a mandated reporter or covered individual thinks, based on information readily obtained from various sources, it is ***possible*** that something happened. Sources of information may include: ▪ Personal observation of the incident; ▪ The resident who is subject of incident; ▪ Incident logs, medical records, etc.; ▪ Other persons who may have relevant information; ▪ Resident behavior; ▪ Other relevant information. A reporter may rely upon one or more of the above sources.	RCW 74.34.035 and/or federal law requires a mandated reporter or a covered individual to: **1. Report *immediately* to the Department when there is:** • A reason to suspect that sexual assault has occurred. • A reason to suspect that physical assault has occurred or there is reasonable cause to believe that an act has caused fear of imminent harm. • The requirement to report to the Department does *not* include an exception for resident to resident assault. **2. Report *immediately* to the appropriate law enforcement agency when there is:** • A reason to suspect that sexual assault has occurred.	**EXAMPLES OF REASON TO SUSPECT or REASONABLE SUSPICION** may include but are not limited to the following: ▪ Large bruises located on the head (especially the face/ neck) and the trunk/torso of body; ▪ Resident self-reports of being slapped, choked, kicked, or burned by another resident; ▪ Staff is witnessed taking sexually explicit photos of a nude resident with dementia; ▪ Any physical evidence of rape such bruising in the perineal area, vaginal tears, and abnormal redness or bleeding in the vaginal area.

Definitions	Guidelines & Comments	Examples
NOTE: Per CMS, if a covered individual has a reasonable suspicion that crime has been committed against a resident, a report must be made within two (**2**) hours (for serious bodily harm) or **24** hours (when there is not serious bodily injury).	• A reason to suspect that physical assault has occurred (except when the law does not require reporting of resident to resident physical assault). • Reasonable cause to believe that an act has caused fear of imminent harm. **3. Report *immediately* an incident of physical assault between residents to the appropriate law enforcement agency under the following circumstances:** • When the incident causes more than minor bodily injury and requires more than basic first aid, the injury appears on the back, face, head, neck, chest, breasts, groin, inner thigh, buttock, genital, or anal area; there is a fracture; there is a pattern of physical assault between the same residents or involving the same residents; or there is an attempt to choke a resident. • When the injured resident or his or her legal representative or family member requests that the incident be reported.	
"REASONABLY RELATED" As referenced in RCW 74.34.035 means a prudent person acting with professional knowledge, guided by community and professional standards, and with knowledge of facts and circumstances as established during a thorough investigation, (or by assessment of superficial injuries of unknown source which are not incidents of	Facts and circumstances surrounding the resident may include, but are not limited to, the following: ▪ Their diagnoses; ▪ Their medication regimen; ▪ Their expected or known results of a medical or diagnostic procedure; ▪ Their functional abilities; and ▪ Their normal interaction within and about the nursing home's environment.	**EXAMPLES OF REASONABLY RELATED** may include, but are not limited to, the following: ▪ Normal bruising that results from venipuncture or other parenterally invasive procedures; ▪ Skin tears related to fragile skin;

Definitions	Guidelines & Comments	Examples
"REASONABLY RELATED" (Continued) suspected or alleged abuse or neglect), has good reason to believe that the source of the injury is reasonably connected to the facts and circumstances surrounding the resident.		▪ Bruising in generally vulnerable areas related to certain drug usage such as anti-coagulants or prolonged steroid usage, or bruising associated with other medical conditions such as leukemia.
"VULNERABLE ADULT" as defined in RCW 74.34.020 (17) (a) through (g) includes a person: ▪ Sixty years of age or older who has the functional, mental, or physical inability to care for himself or herself; or ▪ Found incapacitated under RCW 11.88; or ▪ Who has a developmental disability as defined under RCW 71A.10.020(3); or ▪ Admitted to any facility, or ▪ Receiving services from home health, hospice, or home care agencies licensed or required to be licensed under RCW 70.127; or ▪ Receiving services from an individual provider under RCW 74.34.020; or ▪ Who self-directs his or her own care and receives services from a personal aide under Chapter 74.39 RCW.		

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APPENDIX K
KEY TRIGGERS / POSSIBLE CRIMINAL INDICATORS

This appendix includes possible/actual indicators of various types of abuse or neglect of **residents** in skilled nursing facilities or nursing facilities. The appendix does not include everything.

Mandated reporters and covered individuals must consider other possible indicators of all types of abuse, neglect, and, financial exploitation, and, must report reasonable suspicion of a crime against any resident of that facility.

EXPLOITATION/FINANCIAL EXPLOITATION – "KEY TRIGGERS"

Possible/Actual Indicators of Exploitation/Financial Exploitation: An act of forcing, compelling, or exerting undue influence over a resident causing the resident to act in a way that is inconsistent with relevant past behavior, or causing the resident to perform services for the benefit of another. This can include the illegal or improper use of a resident's funds, property, or assets without informed consent that may result in monetary, personal, or other benefit, gain, or profit for the perpetrator; or monetary or personal losses for the resident. Such fraudulent or otherwise illegal, unauthorized or improper acts can deprive a resident of rightful access to, or use of his or her benefits, resources, belongings, or assets

A financial exploiter can be an individual, an institution, or someone who has power of attorney for the resident. It includes the improper use of legal guardianship arrangements or powers of attorney.

"KEY TRIGGERS" for timely action may include, but are not limited to, the following:

- A resident's report of financial exploitation or missing property
- Suspicion/evidence of possible "grooming behaviors" over a period of days, weeks, or months by a potential offender to see how the resident at risk for exploitation, or those close to the intended resident, will respond to a pattern of gifts, treats, extra attention or unrequested help in an effort to win their individual or collective trust
- Any individual who for personal profit or advantage coerces the resident to sign a document, contract, legal form, or any other form designating authority over the resident's finances and property
- Unexplained, sudden changes in bank accounts or banking practices, including disappearance of funds or withdrawal/s of large sums of money from checking, savings or investment accounts of a resident
- Missing bank checks or financial statements/records usually in resident's possession
- Adding additional unauthorized names on a resident's bank signature cards

- Unauthorized withdrawal of resident's funds by an unauthorized party using the resident's ATM card
- Abrupt changes in resident's will or other financial/legal documents without the resident having a full understanding of the consequences
- Abrupt changes in resident's legal or financial representatives without the resident having participated in, or having a full understanding of, these decisions
- Awareness that a resident with cognitive impairment is/was video-taped by family or outside persons, perhaps as a means to document that the resident agrees to decisions that may actually represent potential undue influence by parties known or unknown to the resident
- Personal health, financial or governmental information (health care insurance cards, credit cards, social security number) is taken and misused by any party with unsupervised access to resident or to the resident's confidential information
- Unexplained disappearance of valuable possessions/property from the resident's room without his/her knowledge or consent
- Bills not paid by resident's representative payee despite the money being available to pay bills
- Forged signature/s on financial transactions or on the transfer of titles of property (home in the community) or possessions (automobile) belonging to a resident
- Sudden appearance of previously uninvolved relatives claiming rights to a resident's possessions/resources
- Unexpected sudden transfer of a resident's assets to a family member or someone outside the family
- Providing services that are not necessary, or, denying services that are necessary per a resident's assessment and comprehensive plan of care
- Improper use of official guardianship or power of attorney responsibilities
- Surrogate decision maker or representative payee, who has been given fiduciary responsibility by the resident to pay the facility's bill, is refusing to pay legitimate bills and to meet the resident's needs by taking or using the resident's money or assets for his or her personal gain or profit
- Facility staff persons, caregivers or others "borrow" clothing or other property of one resident to give to another resident (for example, clothing, TV, wheelchair)
- Facility staff use disposable briefs, disposable gloves and other expendable items which were purchased by, or charged to one resident, for another resident's use
- The presence of emotional or psychological abuse can be a potential/actual indicator that financial exploitation may also be occurring
- Potential/actual theft, forgery, identify theft, false identity or pretending to be a legal representative of the resident, or improperly obtaining financial information

are among, but are not the only, examples that need to be reported to local law enforcement

MENTAL ABUSE – "KEY TRIGGERS"

Possible/Actual Indicators of Mental Abuse: Any willful action or inaction of mental, emotional or verbal abuse of a resident that can cause or result in mental, psychological or emotional pain or suffering, anguish, or distress. In instances of abuse of a resident who is unable to express or demonstrate physical harm, pain or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish.

"KEY TRIGGERS" for timely action may include, but are not limited to, the following:

- A resident's report of being verbally, emotionally or mentally mistreated
- Terrorizing and/or threatening harm or deprivation to a resident by use of oral, written or gestured language
- Unexplained withdrawal from and/or inappropriate isolation of a resident from family, friends, or from regular activities
- Ridiculing, yelling, insulting or swearing at a resident which results in mental pain and suffering, anguish or distress
- Denying food, personal property or privileges as a punishment or deprivation
- Inappropriate use of silence to control behavior of resident
- Sudden changes in behaviors that are not in the resident's usual nature, such as, agitation, change in alertness, increased ambivalence, low self-esteem, unusual depression, extreme passivity, reluctance to leave room for fear of certain persons or other residents
- Treating a resident like a child
- Strained or tense relationships, frequent arguments between a staff person or caregiver and the resident
- Intentional and repeated verbal/telephone harassment or physically stalking intended to potentially/actually frighten, intimidate or harass the resident
- Intentionally threatened or actually attempted to cause harm to the resident's health or safety or physical damage the resident's property
- Use of demeaning statements, harassment, threats, insults, humiliation or intimidation
- Purposely withholding cigarettes or some form of desired food, entertainment or requested activities from the resident
- Placing unreasonable restrictions on the resident's mobility, such as, not charging a motorized wheelchair battery so the resident is unable to be independently mobile

- Placing unreasonable restrictions on the resident's ability to communicate, either verbally or in writing, with other residents or other persons of choice
- Presence of emotional or mental abuse may also indicate that financial exploitation might be occurring

NEGLECT – "KEY TRIGGERS"

Possible/Actual Indicators of Neglect: From the ***state*** regulatory perspective, neglect of a resident as defined in RCW 74.34.020(12) means:
(a) A pattern of conduct or inaction by an individual or entity with a duty of care that fails to provide the goods and services that maintain physical or mental health of a vulnerable adult, or, that fails to avoid or prevent physical or mental harm or pain to a vulnerable adult; or

(b) An act or omission by an individual or entity with a duty of care that demonstrates serious disregard of consequences of such magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare or safety, including but not limited to conduct prohibited under RCW 9A.42.100. [Felony crime of Endangerment with a Controlled Substance (Methamphetamine)].

From the ***federa*l** regulatory perspective, as referenced in 42 CFR 488.301 for skilled nursing facilities or nursing facilities, neglect of a resident can also mean the failure of an individual or entity with a duty of care to provide a resident with the goods and services necessary to avoid physical harm, mental anguish, or mental illness, due to their physical or mental impairment or diminished capacity to perform essential self-care tasks.

"KEY TRIGGERS" for timely action may include, but are not limited to, the following:

- Report by a resident of being mistreated or neglected
- Withholding, misusing or delaying food, fluids, clothing, shelter, personal hygiene, medicine, comfort, safety, help or other needed supports (eyeglasses, hearing aids, mobility equipment) or other essentials included in an implied or contractual agreement of responsibility to a resident receiving services
- Unattended/untreated health/dental problems and/or inadequate care of a resident
- Poor personal hygiene with evidence of significant lack of nail care for fingers and/or toes
- Resident is lying/sitting in urine and feces for extended periods of time
- Inadequate medical/health care services, including not having needed medically-necessary prescriptions/medications initially purchased or renewed in a timely manner
- Failure to do medication administration as per the resident's assessed need and agreed upon comprehensive care plan

- Hazardous or unsafe living conditions such as improper wiring, no heat or running water, no functioning toilet
- Unsanitary and unclean living conditions such as dirt, fleas, lice on person, soiled bedding and personal clothing, fecal/urine smell, inadequate clothing
- Allowing the physical environment to deteriorate to the point that residents are subject to hazardous situations, such as electrical, water and structural hazards
- Staff person or caregiver has fallen asleep or is intoxicated while on duty
- Facility residents with cognitive impairments and known potential for assaultive behaviors are left alone and unsupervised
- Failure to feed or assist a dependent resident who requires help with eating
- Resident develops dehydration or malnutrition due to lack of appropriate care
- Failure to carry out orders for treatment, therapy, diagnostic testing, administration of medications, unless refusal by resident
- Failure to provide care and services per the resident's comprehensive care plan in certain circumstances
- Failure to answer a resident's call light or bell in a reasonable time frame or provide assistance as assessed and agreed to as needed for a resident
- Failure to adequately supervise the whereabouts and/or activities of a resident with such assessed needs, resulting in a resident being reported as missing and when found is hypothermic and with substantial injuries of unknown source, cause or circumstance
- Failure to protect a resident from another resident, regardless of whether or not the other resident's actions are willful or due to cognitive impairment
- Failure to report a resident's chest pain and shortness of breath to supervising staff
- Failure to consult with a resident's attending health care practitioner when the resident's condition requires medical consultation or intervention or both
- Failure to assess and evaluate a resident's status or failure to institute care interventions as required by the resident's condition which results in harm to the resident or demonstrates a clear and present danger for harm
- Failure to transfer a resident in need of emergency help/care out of the facility when the resident's condition clearly warrants the transfer and the resident's health, safety or welfare is dependent upon emergency intervention
- Failure of facility staff to refrigerate potentially hazardous food and resident(s) acquire(s) food borne illness
- Failure to provide an adequate number of nutritionally balanced, properly prepared and medically appropriate meals which can or does result in weight loss pattern or other parameters of poor nutritional status that are not the result of a medical condition for the resident(s)

- Pressure ulcer (“bedsore”) development without evidence of resident having one or more predisposing clinical condition/s that may increase risk of pressure ulcer development
- Lack of, or insufficient, treatment of pressure ulcers regardless of cause, such as, drainage/foul odor, dirty or no bandages over ulcers, exposure of bone in ulcer site(s), skin/sores coated with dried stool
- Contractures that become fixed, even in a resident with certain neurological conditions, due to lack of medical consultation or appropriate assessment and management of such a clinical condition

PHYSICAL ABUSE “KEY TRIGGERS”

Possible/Actual Indicators of Physical Abuse: The willful action of inflicting bodily harm or physical mistreatment. Physical abuse includes the use of chemical restraints or physical restraints unless the restraints are consistent with licensing requirements, and includes restraints that are otherwise being used inappropriately. In instances of abuse of a resident who is unable to express or demonstrate physical harm, pain or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish.

“KEY TRIGGERS” for timely action may include, but are not limited to, the following:

- A resident’s report of physical abuse presently or in the recent past
- Unexplained black eyes, welts, pressure marks, lacerations, rope marks, imprint injuries, sprains or dislocations, broken bones, untreated injuries or sores
- Report of, or evidence of, being pushed, slapped, hit, shaken, spit upon, struck with or without an object, pinched, choked, kicked, shoved, prodded or burned
- Tightening a physical device used as a restraint to cause pain
- History of current and/or past broken bones in various stages of healing
- Open wounds, cuts, punctures, untreated injuries in various stages of healing
- Broken eyeglasses/frames with pattern of contusions over bridge of nose
- Sudden change in the resident’s usual behavior
- Staff person or caregiver’s refusal to allow outsiders/visitors to *see* a resident alone
- Finger marks *possibly* associated with being grasped, squeezed or restrained in some manner
- Research findings***** suggest that, when compared to “normal”, “accidental” or “non-intentional” bruises, “***suspicious”, “inflicted, or “abusive”*** **bruises more likely may be:** 1) Significantly larger in size (2 inches in diameter or more); 2) Located on the head (especially the face/neck) and the trunk/torso of the body, rather than predominantly on a resident’s legs or arms; 3) Found on a resident’s

genitals, buttocks, soles of feet, or, arm (right or left, depending on a resident's dominant arm, often raised to block an alleged attack); and, 4) Residents taking medications that interfere with blood coagulation (i.e., warfarin) *may* be more likely to have multiple bruises, but these bruises usually do *not* last any longer than bruises of residents *not* on such medications. *Wiglesworth, Austin, Corona, Schneider, Liao, Gibbs, & Mosqueda. (2009). Bruising as a marker of physical elder abuse**.*** ***Journal of the American Geriatrics Society, 57*****,** 1191-1196.

- Bruises of varying sizes and ages in locations not usually susceptible to trauma (head, inner arms/thighs, ears, scalp, buttocks)
- Multiple emergency room visits for unexplained, implausible or vague explanations for ill-health or injuries
- Delay between onset of illness or detection of injury (spiral fracture) and actions to seek medical or emergency treatment
- Malnutrition or dehydration without illness/disease-related causes
- Burns to the palms of hands, soles of feet, buttocks that may conform to shape of the allegedly heated object
- Immersion burns of hands/wrists and/or feet/ankles with likely bilateral burn symmetry like "gloves" or "stockings" on upper or lower limbs
- Physical punishment, confinement or involuntary seclusion
- Throwing food or water on a resident
- Use of chemical restraints or physical restraints unless the restraints are consistent with licensing requirements, and, this includes restraints that are otherwise being used inappropriately
- Controlling behavior through corporal punishment such as withholding food and medications
- Pulling a resident's hair or pinching a resident's cheeks to get him or her to open their mouth
- Hair loss with red or "spongy" scalp

SEXUAL ABUSE "KEY TRIGGERS"

Possible/Actual Indicators of Sexual Abuse: Any form of non-consensual sexual contact of any kind that can result from threats, force or inability of the resident to give consent. Sexual abuse also includes any sexual contact between a staff person who is not a resident or client of a facility or a staff person of a program authorized under chapter 71A.12 RCW and a resident or client living in that facility or receiving service from a program authorized by chapter 71A.12 RCW, whether or not it is consensual. (Chapter 71A.12 RCW is State Services for Persons with Developmental Disabilities.)

Sexual abuse/assault includes but is not limited to any nonconsensual sexual contact, such as unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. Remember, ***sexual contact*** may also

include interactions that do *NOT* involve touching. In instances of abuse of a resident who is unable to express or demonstrate physical harm, pain or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish.

"KEY TRIGGERS" for timely action may include, but are not limited to, the following:

- A resident's report of being sexually assaulted or raped currently or in the recent past
- Non-touching offense such as voyeurism by a staff person, caregiver or anyone in a position of power over resident(s), including but not limited to: knowingly viewing, photographing or filming a resident for the purpose of arousing or gratifying sexual desire without the knowledge or consent of the resident and in a place where the resident would have a reasonable expectation of privacy
- Forcing the resident receiving services to view pornographic material in any media form, even if no inappropriate physical touching takes place
- Unwarranted, intrusive intimate touching of the resident receiving services by any facility staff during bathing, dressing, toileting, incontinence care
- Molesting the resident receiving services including unwanted touching and forced kissing
- A family member displays affectionate gestures to a resident that are observed to progress to be too lingering and possibly seductive in nature
- A staff member, caregiver, volunteer or family member takes nude photograph/s of one or more residents
- Any sexual activity (such as, rape, sodomy, sexual penetration, sexual harassment, sexual threats and coercion, sexually explicit photographing) that occurs when the resident cannot or does not consent
- Any sexual contact (such as, staff asking resident for sexual touching, kissing, intimate hugging, "dating") between a staff person and a resident or client living in a facility or receiving service from a contracted program authorized under chapter 71A.12 RCW, whether or not it is consensual

- A staff member or caregiver exposes his/her genitals to a resident
- Bite marks, bleeding, bruising, infection, scarring, or irritation in or near the resident's genitals, thighs, rectum, mouth or breasts
- Unexplained sexually transmitted disease or genital/anal pain, itching, discharge or infection
- Unexplained bleeding, wounds or pain from orifices (oral, vaginal, anal) or intermittent vaginal or anal spotting or bleeding
- Torn, stained, or bloody underclothing including incontinence care products
- Belatedly recognized pregnancy or possible miscarriage of a pregnancy

- Any physical evidence of rape such as bruising in the perineal area, vaginal tears, abnormal redness/ bleeding or pain in the vaginal or anal areas, or, the potential for or actual presence of semen
- Sending a resident sexually explicit messages
- Cueing or encouraging a resident to perform sexual acts
- Resident demonstrates atypical regressive behaviors (withdrawal, shying away from being touched, depression, difficulty eating or sleeping, difficulty walking or sitting, fear) in the presence of a particular staff person or caregiver or other people with unsupervised access to the resident in the facility or on outings
- Resident reacts to possible offender in inappropriate or romantic ways
- Comments of potential concern made by a resident, such as, “She is my girlfriend;” “He loves me;” or, “I’m his favorite girl.”

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APPENDIX L
PROTECTING SENIORS/TAXPAYERS FROM FRAUD

Washington State Office of the Attorney General
Medicaid Fraud Control Unit
P.O. Box 40114 - Olympia, WA 98504
Phone: (360) 586-8888
Fax: (360) 586-8877
MFCUreferrals@atg.wa.gov

WHAT IS MEDICAID?

Medicaid is health insurance for qualifying low-income and needy people. Medicaid eligible recipients can include children, the elderly and persons with a disability. Each state designs and administers its own Medicaid program. The federal government jointly funds the program with the state as long as the program complies with the requirements mandated by the Centers for Medicaid and Medicare Services (CMS).

WHAT IS MEDICAID FRAUD?

Medicaid Fraud is generally defined as the billing of the Medicaid program for services, drugs, or supplies that are: unnecessary; not performed; more costly than those actually performed; purportedly covered items which were not actually covered.

MEDICAID COVERED SERVICES

Medicaid covered services include in-home care, respite care, hospital care, skilled nursing home care, residential adult family care services, and professional services provided by physicians, laboratories and other health care professionals.

MEDICAID FRAUD CONTROL UNIT

Established in 1978, the Washington State Medicaid Fraud Control Unit (MFCU) investigates and prosecutes fraud committed by Medicaid providers. This Unit also monitors complaints of resident abuse or neglect in Medicaid funded nursing homes, adult family homes and boarding homes. This Unit provides assistance to law enforcement in investigating and prosecuting facility-based crimes committed against vulnerable adults. The MFCU also independently investigates and prosecutes provider fraud committed against the Medicaid program, regardless of the location of the offense (the fraud can occur in home, in a facility, in a provider's office, or any other location in Washington). This Unit is part of the Criminal Justice Division of the Attorney General's Office.

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NOTICE

Concerned about abuse, neglect or violation of the rights of a resident in a nursing home, adult family home, or boarding home? Contact:

Aging & Disability Services Administration
1-800-562-6078

TTY Users 1-800-737-7931

If you need help in resolving any problems or questions about adult family homes, nursing homes, and boarding homes, contact: STATE OMBUDSMAN

1-800-562-6028

January 2003

Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

It is the policy of the Department of Social and Health Services that no person shall be subjected to discrimination in this agency or its contractors because of race, color, national origin, sex, age, religion, creed, marital status, disabled or Vietnam Era veteran status, or the presence of any physical, mental, or sensory handicap.